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Examining the effects of political decentralisation in Kenya on health sector  
planning and budgeting: a case study of Kilifi County.

Tsofa Benjamin Karabu


Thesis submitted in accordance with the requirements for the degree of  
Doctor of Public Health (DrPH)  
of the  
University of London  
2015

Department of Global Health and Development  
Faculty of Public Health and Policy  
London School of Hygiene and Tropical Medicine

Funded by: The KEMRI-Wellcome Trust Research Programme  
Research group affiliation: Resilient and Responsive Health Systems (RESYST)

## **Declaration by candidate**

I, Tsofa Benjamin confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed : 

Date : 03/12/2015

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This thesis is dedicated to my daughter Natalie Nadzua.

## **DrPH Integrating Statement**

I recently received a telephone call from a friend who works as the WHO Health System Advisor, based at the Kenyan country office. After exchanging our usual pleasantries, our brief discussion went as below;

“...Chief when are you coming to Nairobi next?” “Early next month” – I replied. “Okay. Could you let me know when you are around? There are two issues I want us to brainstorm about. One as part of our Health Systems Strengthening Project for the counties, we are thinking of developing a framework that will be able to track different aspects of health governance in the counties over time; and try and link those aspects with the overall county health sector performance outcomes; and secondly you know the KHSSP (Kenya Health Sector Strategic Plan) is almost due for a mid-term evaluation, I want us to start thinking about an evaluation framework”. “Yeah sure – we can link those to evaluation processes”, I replied. “Yes, exactly! That’s why I want us to brainstorm on how to go about that”. “Ok.” “So you do let me know when you come over to Nairobi and we can meet and discuss this over a drink” “Ooh sure, I will definitely look for you .....

After I concluded this telephone call, I sunk on my office seat thinking “this ability to contribute to thinking on how to make the health system in Kenya function better is exactly what I was aiming for when I chose to pursue the DrPH course”. Reflecting on this telephone discussion and my experiences over the past four years gave me a high level of satisfaction with my DrPH course intention and experience.

The London School of Hygiene and Tropical Medicine’s (LSHTM) DrPH degree is described as a professional doctorate specifically designed to provide candidates with skills necessary for leadership roles in a broad range of public health practice. The course is uniquely organised into three components: a taught component running for one term at the school, an Organisational and Policy Analysis (OPA) project running for six to twelve months and a research thesis component running for two and a half to three years.

I undertook my taught component in September 2011. This component comprised of two advanced courses; Leadership, Management and Professional Development (LMPD) and Evidence Based Public Health Policy and Practice (EBPHP). Having registered for the DrPH after having worked as a district health manager in Kenya before, my specific interest for the course was to acquire additional leadership and management skills, and obtain skills for

accessing, synthesising and applying evidence for planning and overall decision making within the health sector.

The LMPD course not only provided me with unique leadership and management skills applicable to health sector organisational settings; but also through well organised coaching and mentorship sessions provided me with an opportunity for reflecting on my own thinking and approaches to leading and managing people. In addition to providing me with skills for accessing, appraising and synthesising research evidence, the EBPHP course also provided me with skills for packaging and communicating evidence to different actor audiences in the health sector.

I undertook my OPA in the Policy and Planning Department at the Ministry of Health (MoH) headquarters in Kenya, where I was attached for eight months. My OPA project specifically focused on examining the level of alignment between technical priority setting and financial budgeting within the Annual Operational Planning and budgeting processes in the Kenyan health sector. While at the MoH headquarters, I was co-opted into the MoH planning Core Team, which was at the time leading the development of a new national health policy and strategic plan for the ministry; the Kenya Health Policy (KHP) 2012-30 and the Kenya Health Sector Strategic Plan (KHSSP) 2012-2017. My active involvement in the development of these two important sector policy documents gave me a first-hand opportunity to influence their design and content. In addition, during the process of conducting my OPA, I was tasked to review and revise the MoH AOP planning tools and guidelines for sub-national levels.

I conceived my thesis research question while working with colleagues at the KEMRI-Wellcome Trust Research programme in Kilifi in a broader study on Health System Governance. This governance research is part of a broader multi-country DfID funded research consortium called Resilient and Responsive Health System (RESYST). My thesis research, which builds on my OPA work, aimed at examining how the planned devolution in Kenya was going to affect governance and accountability structures and practices for health sector planning and budgeting at county level in Kenya.

In the process of conducting my thesis research, I have been participating in several high level health sector policy discussions, particularly regarding health sector devolution, at both National level in Kenya, and in Kilifi County. This policy engagement and involvement has provided me with a unique opportunity to facilitate a real-time feedback of my research work into shaping the implementation of health sector devolution in Kenya.



In terms of scientific productivity, in addition to writing my OPA report and this thesis, I have authored and published one, first author peer reviewed paper from my OPA work, and have co-authored two other related published papers with the ‘learning site’ colleagues. I currently have three other first author draft manuscripts from my thesis research work ready for submission to journals. I have also been able to present my work in several high level national and international scientific conferences and meetings. In the recent past, I have received invitations and requests to be involved in either joint research grant applications, or protocol development for several aspects of health systems governance and health policy research work across Africa.

In terms of professional and personal development; in the process of conducting my research work, I received formal appointment as a technical advisor and member of the Policy and Planning Technical Working Group in the Kenya MoH. More recently, and in recognition of the unique skills and experience that I have acquired through the DrPH, the Board of Management of the Kenya Medical Research Institute (KEMRI), appointed me as Centre Director of the KEMRI centre in Kilifi; the largest KEMRI centre in the country and host to the internationally renowned KEMRI-Wellcome Trust Research Programme.

In conclusion, I believe the uniqueness of the three components of the DrPH programme have equipped me with the skills and the experience for leadership roles in health research and health policy, which is what I desired when I was joining the course.

## **Abstract**

Health sector decentralisation has been a recurring theme in health systems reform discourse for several decades, particularly in developing countries. Decentralisation is promoted for its ability to strengthen community participation and accountability, and to enhance technical efficiency in the management of limited health sector resources. However, most of the literature on health sector decentralisation has been descriptive, reporting outcomes of different decentralisation models, with minimal analysis of how contextual factors contribute to the observed outcomes. In 2010, Kenya passed a new constitution through a nationwide public referendum. A key feature of this constitution was the introduction of 47 semi-autonomous devolved county governments.

This study aimed to describe and analyse the effects of this major political decentralization on planning and budgeting in the health sector at the sub-national level, including the goals and intended strategies for health sector operational planning and budgeting, and stakeholder expectations and experiences of decentralisation.

I used a case study design, focusing on Kilifi County, guided by a conceptual framework which drew on decentralisation and policy analysis theories. I used three tracers: planning and budgeting for recurrent expenditures; Human Resources for Health (HRH); and Essential Medicines and Medical Supplies (EMMS) management. I collected qualitative data through document reviews, key informant interviews, and participant and non-participant observations.

I found that the Kenyan devolution was largely driven by the need to address political rather than technical challenges in public sector management. To this effect, county level functions were rapidly transferred without proper structures and capacity to undertake these functions leading to major disruption of public services at county level. Within the health sector, the early days witnessed perverse re-centralisation of operational financial management roles from health facility level to the county level. On HRH, there were major disruptions in staff salary payments, political interference with HRH management functions and confusion over certain HRH management roles; leading to industrial strikes and mass resignations by health workers. On EMMS, there were significant delays in the procurement process leading to long periods of stock outs of essential drugs in health facilities.

With time though, and with the county governments establishing their structures and progressively building their capacity, a general improvement in counties' ability to manage devolved functions, including health sector functions has been witnessed and there are deliberate efforts to find local level solutions to some of the emerging challenges.

In conclusion I argue that the political push for decentralisation is often stronger than the technical intentions and implementation processes. There is thus need for health sector policy actors to have a broader understanding of the countries' political context whenever designing technical strategies for implementing health sector decentralisation. In addition, I propose that the allocation of functions between central level and decentralised units should always be guided by considerations around decision space, organisational structure and capacity, and accountability arrangements and practices within the health system.

## Abbreviations

AIE	Authority to Incur Expenditure
AoP	Annual Operational Plan
AU	African Union
AWP	Annual Work Plan
BROP	Budget Review Outlook Paper
CDoH	County Department of Health
CEC	County Executive Committee
CHMT	County Health Management Team
CIC	Commission of Implementation of the Constitution
CIDP	County Integrated Development Plan
CORD	Coalition for Reform and Democracy
CoG	Council of Governors
CPSB	County Public Services Board
CRA	Commission of Revenue Allocation
DFRD	District Focus for Rural Development
DHMB	District Health Management Board
DHMT	District Health Management Team
DMoH	District Medical Officer of Health
DPHK	Development Partners for Health Kenya
DrPH	Doctor of Public Health
EMMS	Essential Medicines and Medical Supplies
FACT	Factional Analysis and Competency Team
FIF	Facility Improvement Fund
GDP	Gross Domestic Product
HMT	Hospital. Management Team

HRH	Human Resources for Health
HSSF	Health Sector Services Fund
JICA	Japanese Agency for International Development
KADU	Kenya African Democratic Union
KANU	Kenya African National Union
KEMRI	Kenya Medical Research Institute
KEMRI-WTRP	KEMRI Wellcome Trust Research Programme
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework 1994 - 2010
KHP	Kenya Health Policy 2012-2030
KPU	Kenya People's Union
LSHTM	London School of Hygiene and Tropical Medicine
MCA	Member of County Assembly
MoH	Ministry of Health
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
MP	Member of Parliament
NARC	National Rainbow Coalition
NHSSP2	National Health Sector Strategic Plan 2
ODM	Orange Democratic Movement
OPA	Organisation and Policy Analysis
PFM	Public Finance Management
PHMT	Provincial Health Management Team

PNU	Party of National Unity
RAC	Resource Allocation Criteria
RESYT	Resilient and Responsive Health Systems
RH	Reproductive Health
SCHMT	Sub-County Health Management Team
TA	Transition Authority
UKaid	United Kingdom Agency for International Development
UN	United Nations
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

# Chapter 1: Introduction and Background

## 1.0. Problem statement

Proponents of public sector decentralisation have promoted it for two broad reasons. It has been argued that decentralisation allows for community participation in public governance, thus promoting public accountability and ownership of public systems [1, 2]; and it is also promoted as a way of addressing the problems of institutional inefficiency that are characteristic of the public sector [3-5].

Within the health sector context, a call for participation and involvement of communities in their health matters began from the days of the *Alma Ata declaration* in 1978 [6]. In the early 1990s, with the publication of the *World Development Report 1993: Investing in Health*, the World Bank (WB) began advocating for good governance in the health sector through decentralisation [5]. Ever since, health systems decentralisation has become a recurring theme and an important objective in ongoing health sector reforms, particularly in developing countries [7, 8].

Even with its growing popularity as a health system ‘bad governance fix’ in many developing countries, the experiences and outcomes of health sector decentralisation in most developing countries have been quite varied [8], irrespective of the *form* or *mode* of decentralisation adopted [9]. Intended goals have often not been achieved, and perverse outcomes have often been documented [8]. This has led to a common recognition that irrespective of the form and mode of health sector decentralisation, its effects and outcomes are highly dependent on many contextual factors [3, 4, 8].

In the literature many studies of health sector decentralisation have tended to be descriptive; often presenting and/or comparing effects, experiences and outcomes of different health system tracers as a result of different forms of decentralisation [10]. Although it has been acknowledged that the ways in which decentralisation affects the health system have more to do with contextual factors than the mode or form of decentralisation adopted [8, 11], few studies have analysed how contextual factors external (or ‘extra’) and internal (or ‘intra’) to the health sector have interacted to shape and influence how decentralisation policies have been experienced and implemented [10].

In the context of health policy implementation, the complex interaction between existing practices and new policies has commonly been acknowledged by health policy analysts as the phenomenon that largely explains the ‘gap’ between policy intent and policy implementation

[12]. Moreover, there is now an emerging consensus among health policy analysts that studies should strive to go further and deeper to explore and seek to explain ‘*Why*’ and ‘*How*’ a range of contextual factors interact with policy intentions, to produce observed or experienced policy outcomes in a given context [13, 14]. This discourse has also advanced the argument for the need to place ‘actors’ at the central foci of policy analysis because of their roles in shaping, framing and influencing policy implementation processes [14, 15]. These arguments are particularly relevant when investigating and analysing decentralisation policies, which largely involve shifting of the socially and politically contentious concept of ‘power’ [4].

### **1.1. Scope of this thesis**

This thesis aims to contribute to the scanty literature that has sought to examine how health sector decentralisation is influenced by the broader context in which decentralisation policies are placed on the agenda, negotiated, framed, developed and implemented. I thus designed this study as a descriptive, exploratory and explanatory inquiry. I employed various decentralisation, organisational, accountability and policy analysis theories and frameworks to examine and analyse the effects of political decentralisation in Kenya on sub-national level health sector planning and budgeting. Specifically, I used planning and budgeting for recurrent expenditures, Human Resources for Health (HRH), and Essential Medicines and Medical Supplies (EMMS) management as the tracer elements for examining the implementation of decentralisation in the health sector.

This study not only sought to understand the goals and intentions of devolution law and its immediate implementation outcomes (the what?), but also the rationale behind its design, and influences on implementation processes and outcomes. In addition, the study aimed to identify potential strategies to enhance implementation processes and thereby support the achievement of devolution goals and intentions within the health sector in Kenya. Although I conducted the data collection in the early days of the implementation of the devolved government system in the country, I made a deliberate attempt to explore historical data and information so as to enhance the understanding of the intentions that led to the drafting of the devolution laws, and the unfolding events during the implementation process.

### **1.2. Definition and description of key terms and concepts**

Considering the relative breadth of the study topic and the occasional overlap of key terms and concepts used in this area, in this section I present definitions of some of these common and often overlapping terms and concepts, as I applied and used them in this study, and as presented in this thesis.



### **1.2.1. Governance**

The United Nations Development Programme (UNDP) broadly defines governance as a set of mechanisms that allow for the exercise of political, economic and executive authority and obligations over the management of public affairs [16]. ‘Good governance’ has been argued to be essential for economic and social growth and development in any society [16, 17], with good governance often perceived to include participation of the population for whom decisions are made, in a transparent, accountable and responsive manner, as well as the achievement of technical and economic efficiency [16].

### **1.2.2. Accountability**

Public sector accountability takes a broad range of forms and mechanisms. However, the main focus is generally on answerability by those in positions of responsibility to the public over decisions they make while in those positions [18]. Accountability of the public system to the general public is widely perceived as an essential characteristic of good governance [17, 18].

### **1.2.3. Health systems governance**

The World Health Organisation (WHO) recognises ‘health systems governance’ as the central core of the six building blocks of the health system [19]. Though acknowledged as an important element of the health system because of its central role in holding the other elements together, both theoretical and empirical literature on health systems governance is scanty, making it the least understood health system building block [17].

### **1.2.4. Decentralisation**

Decentralisation is generally defined as the transfer of power and authority over management of public affairs from a central level of government to sub-national levels [20]. Depending on the form and model of the decentralisation, the power and authority transferred could be regarding revenue generation, planning, budgeting and general public resource management and decision making, and the sub-national units can be elected directly by the population, appointed by the central level or be private entities [3, 9, 20]. Because decentralisation involves shifts of power and authority over public resources, it is inevitably a highly political process [4].

### **1.2.5. Health sector planning and budgeting**

Health sector planning can be viewed from two broad perspectives. First, as a continuum of the health policy making process, through the formulation of long term strategies such as health sector strategic plans and medium term plans. Second, it can be viewed as a management tool for implementing the long term strategic plans through short term implementation plans or day-

to-day operational plans and budgets. The latter is commonly referred to as health sector operational planning and budgeting [21-23]. Though often viewed as a technical process involving goals, objectives and target setting, health planning is often largely a political process that involves balancing the interests of different actors, and making important and complex choices between alternatives with different social, economic and political consequences [24]. Given the very political nature of health planning processes, particularly where there is negotiation and allocation of limited resources, ‘good governance’ principles such as accountability and community participation are key.

### **1.3. Organisation of this thesis**

This thesis is organised in ten chapters.

This chapter has presented a general background of the thesis, outlining the scope and organisation of the thesis, and key concepts and definitions. Chapter two is the main literature review, presenting theoretical frameworks that have been used to analyse decentralisation, and key empirical findings of health sector decentralisation studies in low and middle income countries with a focus on the tracers for this study: operational planning and budgeting, human resource management and the management of essential medicines and medical supplies.

Chapter three presents a detailed account of the study setting giving a background of Kenya, including highlights in the historical evolution of the decentralisation debate, and an overview of the organisation of the health system with a focus on planning and budgeting.

In chapter four I provide a detailed description of the study, highlighting the study question, objectives, conceptual framework, and methodological details.

Chapters five to eight cover the study findings: the broader context of devolution in Kenya (chapter 5); followed by decentralisation effects on planning and budgeting (chapter 6); health workforce management (chapter 7); and management of essential medicines and medical supplies (chapter 8). In chapter nine I discuss the study findings in relation to the study conceptual framework and relevant literature, and in chapter ten I provide an overall summary of the study and the conclusions and recommendations.

## **Chapter 2: Literature Review**

### **2.0 Introduction**

This chapter has three main parts. Part one focusses on the review of literature on theoretical and conceptual frameworks specific to analysing decentralization. The second part reviews the empirical literature with a focus on the effects of health systems decentralization on operational planning and budgeting, Human Resources for Health (HRH) management; and the management of Essential Medicines and Medical Supplies (EMMS) in low and middle income countries. Finally, the third part reviews key theoretical and conceptual frameworks of health sector governance, and for political, organizational and policy analysis, in the context of health sector decentralization. These frameworks are not specifically designed to examine decentralisation but emerged through my review of the empirical studies as of central relevance to this study.

### **2.1. Theoretical frameworks for analysing decentralization**

Decentralisation is a complex concept with many different modes and forms [9], with the final nature, outcomes and effects of decentralisation the result of many internal and external contextual factors [7, 8]. The complex nature of decentralisation has made it a difficult phenomenon to measure in the real world setting [4, 11]. The literature on conceptual and analytical frameworks for examining decentralisation is very limited with no agreed ‘ideal’ framework [11]. Commonly cited frameworks and analytical approaches have their roots in the development sector, and include the social capital framework, the local fiscal choice framework, the public administration framework; and the principal agent framework. Here I describe the social capital and local fiscal choice frameworks briefly as they have not been widely used in studies of health sector decentralisation. I then describe in more detail the public administration and principal agent frameworks which have been used more often in studying health sector decentralisation and which I draw on more heavily in this study.

#### **2.1.1. Social capital framework**

This framework was first used by Putnam in his studies of decentralisation in Italy. In this framework, Putnam tried to explain the reason why some decentralised units in a devolved system perform better than others. He observed that in better performing units, there is usually a wide range of voluntary and civil organisations which he called ‘social capital’, that serve to encourage people to work more closely together [25]. This framework has however had very limited application in studies of health system decentralisation [11].

### **2.1.2. Local fiscal choice framework**

This framework was first described and used by economists Musgrave and Musgrave to analyse expenditure choices made by local governments for locally generated revenue, and for resources transferred from central government [26]. The framework assumes that local governments make choices that are in the best interests of and are most popular with ‘local voters’. This framework has been used largely in development studies of federalism in high income countries, with its application in developing country contexts limited because revenue collection through taxation is usually a responsibility of central government, with minimal local revenue generation. In many developing countries, the resources received from central government are accompanied by administrative restrictions, limiting the space for local decisions and choices [11].

### **2.1.3. Public administration framework**

This framework was first described and used by Rondinelli and Cheema (1983) in their studies of decentralisation and public policy in developing countries in the early 1980s [9]. It largely focuses on the legal status of the distribution of authority and responsibility over public affairs between central level government and the lower level authority. It describes a four-type classification of different forms of decentralisation based on the legal status:

1. *Devolution*: defined as the transfer of power and authority over public service delivery from central level government to elected semi-autonomous sub-national government structures. The sub-national level of government shoulders some degree of responsibility and accountability directly to the population over the functions assigned to it.
2. *De-concentration*: defined as the transfer of certain administrative and implementation roles and duties to sub-national government units. These sub-national government units are subordinate to the central government. Authority and responsibility over the services delivered by these units is retained at the centre.
3. *Delegation*: defined as the transfer of some authority and roles of public service delivery to semi-autonomous government agencies like boards and parastatals. These semi-autonomous agencies are usually appointed by, and are accountable to, the central government, and the responsibility to the population lies with the central government.
4. *Privatisation*: described as the transfer of service delivery responsibility, and at times ownership of public institutions, to private entities.

The public administration framework has been useful in examining decentralisation because it provides an obviously observable classification of institutional arrangements under the

different decentralisation models [11]. It is however quite limited as an analytical framework in that it does not provide for analysing the functions that are decentralised, and the context of the decentralisation [4, 11]. Within the health sector, this framework was first applied by Mills et al., (1990) to examine health system decentralisation in a World Health Organisation (WHO) study that involved ten country case studies [8]. Since then, this framework has been strongly promoted by the WHO to examine decentralised health systems. Though still widely cited today, a number of authors [4, 27, 28] have criticised this framework, arguing that de-concentration and privatisation should not be classified as forms of public sector decentralisation. Their argument is that the former is just a form of field administration of a centralised system, while the latter involves private institutions whose nature of business engagements is different from public institutions. Other authors have also argued that in practical terms, most health systems are made up of a mixture of more than one of these decentralisation categories [3, 4].

#### **2.1.4. Principal agent and decision space frameworks**

This framework was developed by economists Pratt and Zechauser, initially to study the choices made by managers of private institutions. The framework describes a principal, who could be an individual or institution with a specific objective, and an agent who is tasked by the principal to undertake certain activities and tasks to meet the objectives of the principal [29].

Within the health sector, Bossert (1998) used the principles of the principal agent framework to develop the *decision space framework* for analysing health sector decentralisation. In his decision space framework, Bossert described the ‘principal’ as a central government entity with a health service delivery mandate that it transfers to an ‘agent’, which he describes as a peripheral entity. In this framework, Bossert argues that there is always a range of effective choices that the ‘agent’ is allowed by the ‘principal’ to make. He further argues these choices are often defined within laws and guidelines; but often the ‘actual’ choices that the ‘agent’ ends up taking often include ‘bending the law’ because of the inability of the ‘principal’ to reinforce adherence of the rules. It is this total range of choices that the ‘agent’ ends up taking as outlined in the rules, and due to their ability to ‘bend the rules’ that Bossert described as *decision space* [11]. Bossert’s decision space framework can be seen as a more practical adaptation of the principal agent approach in that beyond examining the relationship between the ‘principal’ and the ‘agent’, it goes further to examine the range and types of choices that the ‘agent’ makes. It has been used by Bossert and his colleagues in several studies of health system decentralisation,

in a number of countries [11, 27, 30-32]. More recently, Bossert and Mitchell (2011) in a study of decentralisation in Pakistan developed a framework that sought to improve the decision space framework. In this improved framework, they argue that in decentralised settings, organisational structure and capacity, coupled with accountability structures and mechanisms, often act together to interact with and influence decision space [30].

## **2.2. Empirical literature on health sector decentralization**

In this section, I outline and present findings of a detailed literature review that I carried out to answer questions that were emerging as important within the implementation of the new political decentralization in Kenya, including the effect of decentralization on a) resource allocation, recurrent operational planning and budgeting, b) Human Resources for Health (HRH) management and c) management of Essential Medicines and Medical Supplies (EMMS).

These questions were partly informed by the findings from an initial review of the broad concepts of decentralization and health sector planning; and partly by the initial review of documents on the intended goals of decentralization in the health sector in Kenya. These were further refined after initial discussions with key health sector stakeholders on their understanding and expectation of the planned decentralisation in Kenya. From the initial discussion with key health sector stakeholders, it emerged that the new decentralization in Kenya was going to transfer significant health sector priority setting, planning and budgeting responsibilities from national to county level. These would include responsibility for: all health sector investments including employment, deployment and overall management of health care workers; purchase, distribution and overall management of EMMS; infrastructure development; and major equipment purchase and distribution. All of these responsibilities were previously undertaken at the national level, suggesting that the planned devolution in Kenya would have a major effect on how the health sector undertakes its planning and budgeting for recurrent resources, HRH and EMMS management [33-38] .

### **2.2.1. Literature search strategy**

I carried out the literature search in Pubmed, Global Health and Google Scholar databases between February and March 2014, and updated the search in June 2015. I also undertook a manual search for the references of articles identified from the online search.

I used the concepts and synonyms in Table 1 as search terms, using them either as free text or as MeSH terms depending on the database. I used the Boolean operator “OR” to combine synonyms and ‘AND’ to combine the different concepts.

The search focused only on articles published in peer reviewed journals in English, reporting empirical primary findings on the effects of health sector decentralization on resource allocation, recurrent/operational planning and budgeting, or on HRH or EMMS management. The review also only focused on studies conducted in Low and Middle Income Countries (LMIC) between January 1983 and December 2014.

I accessed a total of 7,589 papers. In the initial screening, I excluded 7,386 papers on the basis of their titles, and a further 142 after reading the abstracts. I accessed and reviewed the full articles for the remaining 61 papers, leading to the exclusion of a further 32 articles. 29 papers were included in the final review.

Table 1: List of concepts and synonyms used in the literature search

<i>Concept</i>	<i>Synonyms</i>
Decentralization	Decentrali* (Text word) Deconcentrat* (Text word) Devol* (Text word) Delegat* (Text word)
Low and middle countries	Low and middle income countries (Text word) Sub-Saharan Africa (Text word) DEVELOPING COUNTRIES (MeSH Term) AFRICA SOUTH OF THE SAHARA (MeSH Term)
Health workforce	Health work* (Text word) Human resources for health (Text word) Doctors (Text word) Nurses (Text word) HEALTH MANPOWER (MeSH Term)
Essential Medicines and Medical Supplies	Medicin* (Text word) Medical Supplies (Text word) PHARMACEUTICAL PREPARATIONS (MeSH Term)
Resource allocation, Planning and Budgeting	Operational plan* (Text word) Budget* (Text word) Resource allocation (Text word) HEALTH PLANNING (MeSH Term)

Annex 1 is a summary of the final 29 papers included in the review. Of these, 15 reported on studies conducted in Africa, 6 in Asia, 6 in South America and 2 were multi-country studies across regions. A total of 24 studies reported on different aspects of resource allocation, recurrent operational planning and budgeting, 14 on HRH management, and 7 on EMMS. All

studies were described as ‘case studies’, with cases varying from being regions within a country to country level cases. The studies were predominantly qualitative, employing data collection techniques such as record reviews, individual interviews, focus group discussions and observations. Two studies employed a mixed-methods design as they undertook some quantitative data collection and analysis in addition to the qualitative inquiries [31, 39].

## **2.3. Summary of findings from empirical studies reviewed**

In this section, I present a summary of the key findings on the range of effects of decentralization on the health system at a sub-national level for each of the three tracers.

### **2.3.1. Decentralization and resource allocation, operational planning and budgeting**

#### *Resource allocation criteria and practices*

Health sector decentralization had mixed effects on overall country level resource allocation and health sector specific resource allocation practices. An increase in equitable resource allocation across regions was attributed to the adoption of equity-based resource allocation criteria in the Philippines, Pakistan and Colombia [40-42], and to the establishment of an equalization fund in Chile [43]. Conversely, Collins et al (2000) reported that Brazil adopted a standardized resource allocation formula for all of its municipalities, disadvantaging the most needy and exacerbating inequalities [44].

In terms of sources of funding, most studies reported very low local revenue generating capacity in decentralized units, leading to a reliance on centrally allocated sources of funds [27, 41, 42, 45-47]. In some countries, centrally allocated funds to decentralized units were in the form of block grants as reported in Uganda and the Philippines, giving decentralized units more discretionary powers over internal local resource allocation [42, 45]. However in other countries like Tanzania, Ghana, Chile, Bolivia and Brazil, centrally allocated funds were disbursed as conditional grants or earmarked funds thus reducing local level decision space [43, 48, 49]. Some studies also reported the existence of vertical centrally controlled health programmes which were largely donor funded, with significant allocative restrictions as was the case in Tanzania, Uganda and Ghana [48, 50, 51]. Bossert et al (2003) noted that health sector decentralization in Zambia enhanced local level internal health sector resource mobilization through allowing districts to make local decisions on user fees [32].

#### *Recurrent operational planning and budgeting*

Decentralization was associated with increased health sector financial management responsibility and local level and enhanced bottom-up planning processes within the health sector in Indonesia and Pakistan [52-54]. However, Maluka et al (2011) and Frumence et al



(2013) reported that in Tanzania, restrictive centrally controlled planning guidelines and lack of local level planning and budgeting capacity heavily constrained local level planning [47, 55]. In Uganda, Jeppsson (2001) noted that an increase in discretionary authority over local level priority setting led to reduced allocations for Primary Health Care (PHC) activities in decentralized districts to almost a quarter of previous central government allocation. Districts also tended to allocate most of their resources to curative services as opposed to PHC [45]. Okorafor and Thomas (2007) and McIntyre and Kulgman (2003) noted in South Africa that although decentralization increased provincial level financial autonomy, Provinces marginally increased allocation for PHC services on an incremental rather than need basis [46, 56].

### **2.3.2. Decentralization and HRH management**

#### *Decentralized versus centrally controlled HRH management systems*

The studies reviewed reported different levels of discretion by decentralized units for different HRH management functions. In most instances, even within devolved systems, countries tended to decentralize limited aspects of HRH management such as staff appraisals and disciplining while retaining critical functions of recruitment, deployment and salary payments at central level [42, 55, 57-59]. In these countries, it was reported that the retention of critical aspects of HRH management functions at central level was an attempt to mitigate against some of the challenges that had been anticipated or experienced with total decentralization of HRH management functions. In Tanzania for example, after undertaking total decentralization for health worker management to the district level, the country faced several challenges including inability of rural districts to attract and retain highly skilled staff such as medical specialists, leading to unequitable distribution of health workforce [49, 60, 61]. The country therefore re-centralized some of the HRH management functions to address these challenges [61].

#### *Attraction, recruitment and retention of health care workers*

The studies reported divergent effects relating to health care worker attraction, recruitment and retention. Munga et al (2008) reported that decentralization was associated with better rationalization of staff recruitment and actual needs in staff numbers and skills mix, thus leading to better linkage between staff recruitment and budgetary allocation for HRH management in Tanzania. They also noted that decentralized health worker recruitment led to better retention of lower cadre health workers, as most were recruited and deployed within their home locality. Attraction and retention of highly skilled technical health workers was however a challenge in remote districts, as noted above [61]. The tendency for better attraction and retention of lower cadre staff under decentralization led some countries like the Philippines,

Uganda and Chile to limit the decentralized recruitment of health care workers to only primary health workers [27, 59]. In Mozambique, Saide and Stewart (2001) reported that staff recruitment in decentralized provinces was negatively affected by inadequate financial resources and lack of personnel and capacity to properly manage the HRH management function at the provincial level [62].

#### *Health worker salaries, incentives and staff morale*

Decentralization of health worker salary payments was associated with disruption in payments of staff salaries in several countries including the Philippines, Uganda, Tanzania, Ghana, and Zambia [27, 48, 58, 63]. In the Philippines for example, devolved health care workers received up to 40% reduced salaries and benefits due to lack of resources in local governments [27, 42], while in Uganda, Kyaddondo and Whyte (2003) noted that health workers in some rural districts could work for as long as 36 months without salaries [58]. This contributed to several countries with decentralized health systems adopting central management of health worker staff salaries [43, 57, 59]. In addition to disruption in health worker salary payments, devolved districts in Uganda could not afford to pay for continuous in-service training for health care workers, thus affecting their career progression [58]. Similarly, Grundy et al (2003) reported low morale for health workers in the Philippines as a result of health care worker management being undertaken by non-technical political managers who constantly interfered with the technical operations of the health workers. This eventually led to resignations by many health care workers [63].

#### *Managing health care workers during the centralization – decentralization transition*

From the studies that reported on the transition from a centralized to a decentralized HRH management system, the transition period emerged as critical and facing specific challenges. In Nepal for example, as the country adopted a devolved government system, health workers - acting out of fear of losing their jobs and concerns about the ability of districts to continue paying their salaries - went on strike to resist decentralization thus paralyzing the health sector [64]. In Uganda, the decentralization transition saw a confusion in health worker employment terms as some health workers were employed by decentralized districts while others were retained by national level, with the two groups having different terms of employment including salaries [58]. In the Philippines, the decentralization transition was undertaken without prior staff sensitization and was characterized by a poor transfer process which led to mass resignations of health care workers [63]. In Ghana, recruitment, promotion, and discipline of health workers was initially retained centrally but was later delegated to decentralized districts

leading to poor staff retention as a result of uncertainties in career progression and poor working conditions in the districts [48]. In Trinidad and Tobago, decentralized regions recruited new staff while existing staff were given a choice of transfer, secondment or remaining centrally employed [57].

### **2.3.3. Decentralization and EMMS management**

Most of the studies reporting on EMMS management in a decentralized health system context reported that commodity procurement and supply to health facilities was retained as a central function, irrespective of the form and type of decentralization adopted [39, 59, 60]. Central government largely procured drugs and distributed them to health facilities in decentralized units in the form of pre-packaged drug kits, with minimal input from the decentralized units on their size and composition [39, 49, 60]. These centralized EMMS management systems were however often associated with some facilities receiving an inadequate supply of commodities [39]. In Uganda, districts used facility generated revenue in the form of user fees to supplement their drug supplies as the centrally distributed drug kits were inadequate [39].

In their study of effects of decentralization on logistics system in Ghana and Guatemala, Bossert et al (2007) reported that more local level discretion on EMMS management was associated with better prioritization and budgeting for drugs and commodities leading to better fill rates when commodities are ordered [39]. However, lack of adequate capacity for logistics management systems and procurement procedures at local level often resulted in delayed procurement of commodities thus resulting in frequent stock-outs in health facilities. This was also noted in the Philippines by Grundy et al (2003) who also reported frequent commodity stock outs at health facilities due to lack of proper logistics management capacity by local municipalities [31] .

To address the challenge of frequent stock outs of Reproductive Health (RH) commodities in Ghana due to the capacity challenges at a district level, Mayhew (2003) reported that a vertical RH program, which was largely donor funded, established a vertical RH commodity supply system to all health facilities to supplement the locally procured commodities. These commodities supplied through the centrally funded programme were delivered in a timelier manner to the respective health facilities than those procured by the local districts. It was also reported that RH commodities procured by central MoH and distributed to districts were acquired at a lower cost than those procured by local districts directly, even for similar products. This was largely because the central MoH benefited from economies of scale, due to bulk purchases, compared to the local districts [63].

## **2.4. Discussion of empirical studies' findings**

This literature review had several limitations. First, the search for literature only published in English meant that I did not access literature published in other languages, limiting access to experience from LMICs which commonly publish in for example French and Spanish. In addition, the search only focused on literature published in peer reviewed journals. Considering the nature of this subject, there is potentially a significant volume of grey literature that I did not include.

In a WHO commissioned study to review health sector decentralisation in ten countries, Mills et al (1990) concluded that the outcomes of implementing different forms of health sector decentralisation in different countries are highly context specific, and that country level experiences and effects are difficult to generalize [8]. From the findings presented in this review, it is quite evident that health system decentralisation has been, and continues to be, advocated as an important good governance practice for improving the management of certain elements of resource allocation planning and budgeting, HRH, and EMMS [1, 49, 65]. However, the findings of this review also support Mills et al's (1990) observation of context specific influences on the manner in which health sector decentralisation affects these health sector elements.

The effects of health sector decentralization vary with the mode of decentralization and the broader country context, contributing to the complexity of the concept of decentralization and its effects on health system governance outcomes [4, 11]. These findings also revealed that health sector decentralization outcomes are often determined by whether the decentralization implemented is health sector specific, or is part of broader public service decentralization. Moreover, these findings revealed that in routine practice, quite often multiple forms or typologies of decentralization within the health system, and rarely just one single form, exists in any one country at a time [4, 11, 66].

This review shows that decentralisation has a myriad of positive and negative effects on the functioning of sub-national level health systems. On resource allocation, planning and budgeting, decentralisation coupled with deliberate equity policies can bring about equitable resource allocation at sub-national level. However, in most instances, there was minimal capacity for local revenue generation by decentralised units, necessitating the release of central financing for these units. This reliance on central government financing potentially limits the

decision space of decentralised units, especially in instances where the resources allocated to decentralised units are in the form of earmarked or conditional funds.

With regards to HRH management, the literature suggests that certain HRH management functions including recruitment and distribution of highly specialised staff, in-service training, and management of staff salaries are best managed centrally. Other functions like staff appraisals, promotions, recruitment and deployment of lower cadre staff are best handled in decentralised units. On EMMS management functions, the literature suggests that functions like commodity quantification processes are best conducted locally, while the procurement function is best undertaken centrally as it provides opportunities for economies of scale. The literature further suggests that capacity challenges are the most common hindrance of decentralised units' ability to undertake and perform functions assigned to them.

## **2.5. Key, theoretical and conceptual frameworks for health sector governance, political, organizational and policy analysis, in the context of health sector decentralization**

In this section, I review key theoretical and conceptual frameworks for health sector governance, and political, organizational and policy analysis, in the context of health sector decentralization. Though they are not specific to decentralisation, their relevance for this study emerged during my review of the empirical literature on decentralisation.

In a review of literature of frameworks for assessing public sector governance, Siddiqi et al., (2009) developed a framework for analysis of health systems governance based on ten core principles. These principles are strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics [17]. As noted earlier, proponents of 'good governance' have argued that a number of these principles including participation, equity, transparency and accountability can best be achieved through decentralization. Public participation and accountability are themselves two broad areas of research in public sector service delivery, with health just one sector. Different authors have had different definitions of public sector accountability; but what has been common in the different definitions is the issue of obligation by individuals or institutions to provide information or justifications for their actions to other actors, and the imposition of positive and negative sanctions in case of failure to adhere to the obligations [18]. The health sector, like other public service sectors is made of internal (within the system) and external (towards consumers and general population)

accountability mechanisms [18, 67]. Brinkerhoff (2004) developed a matrix for assessing the practice and exercise of accountability by different actors within the health sector. The Brinkerhoff accountability framework matrix bases accountability on the ‘supply’ and ‘demand’ of information by different health sector actors, and the relative strengths by the different actors to demand or supply this information. Core to this framework is the concept of ‘answerability’ and ‘sanctions’ in the exercise of accountability [18].

Several authors have argued that the ‘political drivers’ and political context that push a country to adopting a decentralized governance arrangement have a major bearing on how decentralization gets implemented in a given setting. To this end, a political context analysis has been argued to be key in interpreting findings of studies examining decentralization policies [3, 4, 66]. In their policy analysis triangle, Walt and Gilson (1994) argued that the process of policy formulation and implementation is usually affected and influenced by the policy content, context and actors involved [68]. Within the context of decentralization, this argument has been further advanced by several authors who have stressed that the implementation and outcome of a decentralized system in any setting is highly context specific [4, 8]. Leichter (1994) proposed a framework for examining policy context at the macro level, where he suggested the need to think of structural, situational, cultural and environmental factors when analysing the macro level policy context. Leichter’s framework defines structural factors as more permanent elements of society, cultural factors as societal values, environmental factors as those that are external to the national political system, and situational factors as irregular and impermanent events like political crisis [69].

The organizational capacity by decentralized units, has been argued by several authors to be critical if these units are to deliver on their assigned decentralized roles; and hence harness the benefits of decentralization [30]. The United Nations Development Program (UNDP) defines organizational capacity as the ability of the organization system to perform its mandate appropriately, effectively and efficiently. The UNDP (1998) developed criteria for institutional capacity assessment that have been widely used for assessing government institutions. This (UNDP) capacity assessment criteria assess institutional capacity at three levels. Level one is the system level which focuses on the broader systems within which the organization operates and includes elements like legal and regulatory environment, broader policy, and processes around which the organization operates. Level two is the institutional entity level which focuses on institutional mission, strategy, culture and internal processes. Level three is the individual level focusing on the individuals within the institution and their skills against their job

descriptions [70]. Aragon (2010) proposed a framework to examine organizational capacity. This framework has recently been applied by Elloker et al (2013), and is gaining popularity by health policy analysts in assessing sub-national level health management units, especially in developing country contexts [71-73]. This framework proposes that organizations are made of hardware, software tangible, and software intangible capacity elements that are necessary for optimal functioning of the organizations. Hardware elements include infrastructure, technology and finances. Tangible software includes organization systems and procedures, and management system and procedures. Intangible software elements include communication, relationships, norms and values, and power [73].

With its intended objective of transferring power from one set of actors (national level government) to another (peripheral level government), the nature of the design and implementation process of decentralized systems is often marred with power contestations [66]. Within the health sector, several health policy analysts have argued that power, which is basically defined as the ability to influence other actors, is a key determinant of the processes of health policy formulation and implementation [74, 75]. The notion of power in policy formulation and implementation is however a complex one to analyse as it often presents in many forms, characterized by actions or inactions by different actors in the policy processes [75]. VeneKlasen and Miller's (2002) proposed expression of power theory. In this theory, the authors have argued that during policy and political processes, power is expressed in four main forms namely; power over, power to, power with; and power within. Power over views having power involving taking it from someone else, and then, using it to dominate and prevent others from gaining it, power to views power as a unique potential of every person to shape their life and world, power with concerns the ability to find common ground among different interests so as to build collective strength, and power within views power as a person's sense of self-worth and self-knowledge [76].

## **2.6. Conclusion**

In this chapter, I reviewed the conceptual literature and 29 empirical papers to understand the effects of decentralization on the health system at a sub-national level for each of my three study tracers. I have also reviewed key theoretical and conceptual frameworks for health sector governance, and political, organizational and policy analysis; in the context of health sector decentralization. The literature supports, Bossert and Mitchell's (2011) argument that decision space, organisational structure and capacity, and accountability structures and practices are key

health system internal contextual factors that collectively or individually influence and affect the implementation and outcomes of health system decentralisation [30]. Political drivers or reasons for decentralisation within a particular country are also very key among the country level contextual factors affecting the implementation of any decentralisation design.

However relatively few studies have attempted to analyse how and why broader political and health sector level contextual factors interact with other factors to influence health systems decentralisation outcomes against goals. This study was thus designed with the overall purpose of contributing to addressing this gap in the literature.



## **Chapter 3: Study Setting**

### **3.0 Introduction**

In this chapter I provide a detailed background and description of the study setting to place the study in context. I begin with an overview of how the decentralisation debate and implementation has evolved in Kenya from independence in 1963 up to the introduction of devolved government systems in 2013. For these, I particularly focus on the elements of this evolution that has informed the goals, design and possible implementation process of the devolved government system in Kenya post 2013. I then present a background description of the Kenyan health system and health system planning processes. I conclude the chapter with a background introduction and description of Kilifi County, the case study county where the study was conducted, and describe the institutional setting where I was residing as I conducted this study.

### **3.1. Kenya**

Kenya is a low income country in East Africa. It has an estimated population of 38.6 million people, a GDP per capita of 453 US\$, and an average life expectancy of 55 years for males and 59 years for females [77, 78]. At independence in 1963, the country adopted a federal government system of a devolution model [11, 79]. This was however short-lived and in 1965 a unitary government system with deconcentrated administrative units referred to as districts was adopted [11, 79, 80]. A new constitution adopted in the country in 2010 ushered in a devolved government system, with 47 devolved units called counties [11, 33].

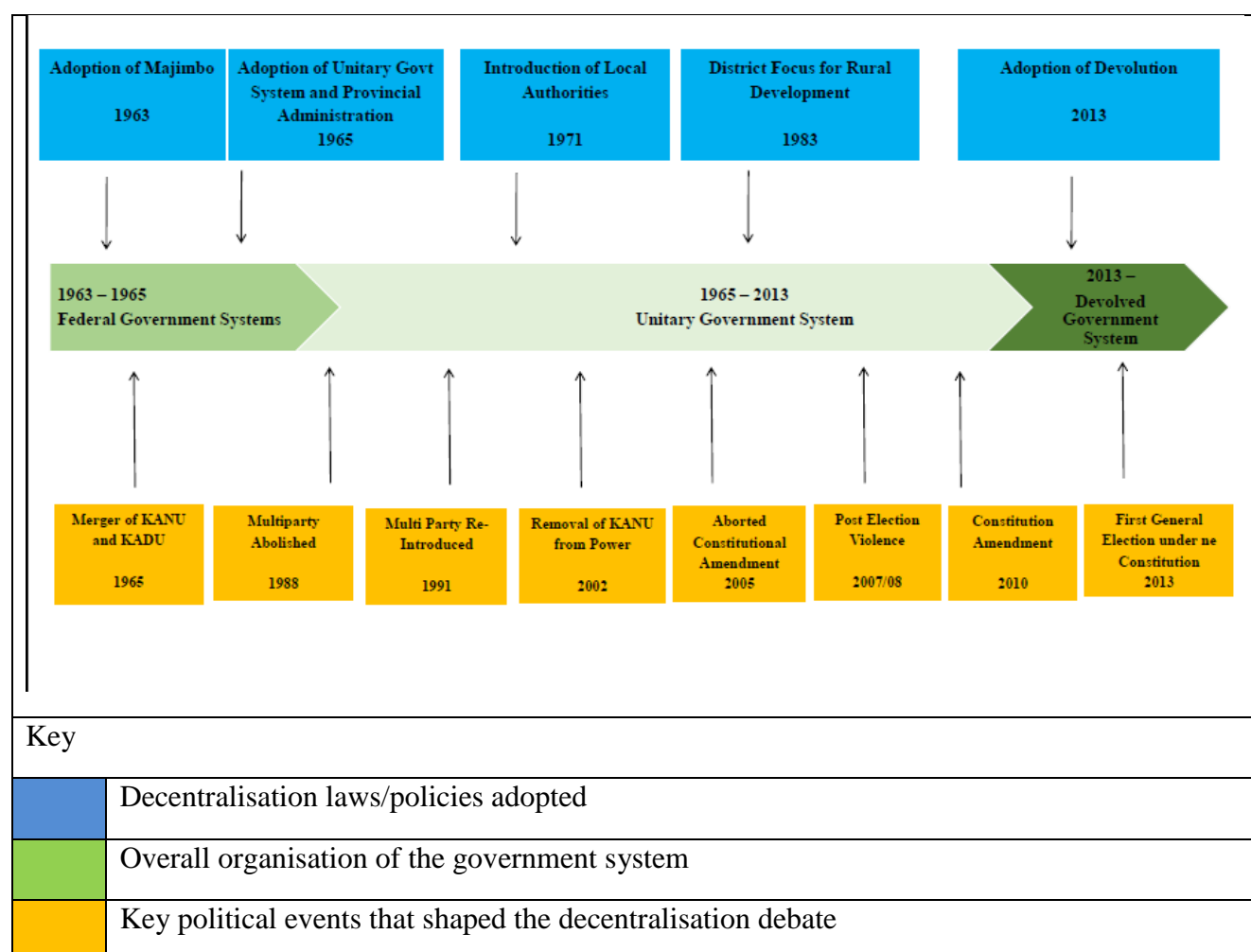
### **3.2. Evolution of the decentralisation debate and implementation in Kenya**

The decentralization debate has persistently dominated the political arena in Kenya since independence [79]. Figure 1 illustrates the main decentralization laws and policies that the country has adopted over time, with key events that have influenced these policies.

At independence, the country adopted a constitution with a federal system of government, with seven federal regions and the Nairobi area [79, 81]. Each region had an executive mandate and authority to provide key public social services particularly in health and education [81]. Each region was made up of several units called districts which were organized as administrative units for coordinating national government functions [80-82]. However, the country's two major political parties at the time ideologically differed on the government system. The then ruling party, the Kenya African National Union (KANU), which drew its major following from

the populous Kikuyu and Luo communities, favored a change to a unitary system of government; while the main opposition party, the Kenya African Democratic Union (KADU), which drew its major following from the Coastal and Rift-Valley communities, favored the federal system of government, popularly known as *Majimbo* [79, 83]. For this reason, the Coast and Rift-Valley regions to date are seen as the originator and champion of devolution [79, 84]. Several years after independence, the KANU and KADU leadership formed a ‘political marriage’ in which they agreed to dissolve KADU and incorporate all the KADU leadership into the KANU led government. Through a parliamentary constitutional amendment, they also agreed to abolish federalism, adopt a unitary government system, and strengthen the coordination role for government services by districts [79].

Figure 1: Schematic illustration of key political events that have shaped decentralization processes and the devolution debate in Kenya over time



In the late 1960s, *Jomo Kenyatta*, the president and leader of KANU, fell out with *Jaramogi Odinga*, his vice president at the time, leading to the latter being expelled from KANU and

being sacked as vice president. *Odinga* moved on, with his regional political following from the Luo-Nyanza region, to register an opposition party, the Kenya Peoples Union (KPU), which became a major critic of the KANU government. Over time the Nyanza region came to be labeled as the ‘mother of opposition’ politics in Kenya. KPU criticized the KANU government for entrenching tribalism, corruption, and regional imbalances in the distribution of national resources and for general maladministration [79, 83].

The KANU government continued over time to adopt policies that entrenched government marginalization of certain regions. The first post-independence long-term government strategic economic development policy document, for example, was seen by the opposition as entrenching this marginalization of certain regions. This policy notably zoned the country into high, medium and low economic potential zones based on population density, agricultural productivity and proximity to the Mombasa-Nairobi-Kisumu railway-line. Government development investment was to be prioritized along the targeted high priority areas [85], creating a situation whereby certain regions in the country were neglected [84, 86].

In the late 1970s and early 1980s the KANU government introduced changes that were presented as increasing decentralisation and community participation. However, these changes served to entrench national government control at local levels. In 1977, a Local Government Act was enacted. This established local authorities managed by elected local leaders, with a mandate to generate local revenue and provide a limited range of social services including aspects of health, education, water and sanitation, and sewerage management services. The local authorities established under this act, depending on their level, were headed by chairmen or mayors elected by the councilors, who were the elected people’s representatives within the local authorities [87]. In 1982, the KANU government abolished the county’s multi-party system and in 1983 launched the District Focus for Rural Development (DFRD) policy. The DFRD policy - which was adopted on the pretext of encouraging citizen’s participation in public resource management - became a way for the national government and the presidency to entrench itself and have control over what happened in all corners of the country [80, 88]. The provincial administration structure which was entrenched by the DFRD was itself seen to be oppressive of the people rather than empowering [80, 82].

In response to what were perceived as oppressive policies there was strong pressure on the KANU government to undertake constitutional and political reforms. In the early 1990s, KANU partly gave in to this pressure and passed a constitutional amendment in parliament to allow for the re-introduction of a multi-party system. However without much change in the

electoral laws, and with the opposition parties divided, KANU won the general elections held in both 1992 and 1997 [89]. At the height of the subsequent 2002 elections, the opposition united to contest the presidential elections under the banner of the National Rainbow Alliance (NARC), with *Mwai Kibaki* as its presidential candidate. The then KANU president *Daniel Moi*, who had served the constitutionally permitted maximum two presidential terms, was not eligible to run for the presidency that year. *Moi* appointed *Uhuru Kenyatta*, a son of *Jomo Kenyatta*, who was at that time considered by many as a political novice, to be the KANU presidential candidate. The choice of *Uhuru Kenyatta* as KANU's presidential candidate led to sharp divisions within KANU, and resulted to several KANU politicians defecting from the party to join the united opposition. NARC's campaign focused on the promise of comprehensive constitutional reforms and it easily won the election that year [90, 91]. The NARC government attempted a constitutional review in 2005, but the two main coalition partners within NARC differed on the nature of government structure proposed in the then draft constitution. This led one wing of the NARC coalition partnership (which presented itself as pro-devolution) to campaign against the passing of the draft constitution in 2005. This 'NO' wing won a national referendum held that year leading to a rejection of the proposed new constitution (that was championed by the side perceived to be anti-devolution) [92, 93].

The opposing sides of the NARC coalition took separate directions after the 2005 referendum, and converted themselves into independent political parties namely the Orange Democratic Movement (ODM) for the 'NO' side, led by *Raila Odinga*, son of *Jaramogi Odinga*, and the Party of National Unity (PNU) for the 'YES' side led by the then president *Mwai Kibaki*. These two parties went on to become the main opposing parties at the general election of 2007. The heightened and divisive campaign period in the run-up of the 2007 general election, coupled with claims by the ODM that PNU, which was declared winner, had rigged the election, led to widespread violence across the country that lasted for several weeks in 2007-08 [92, 93].

It took the intervention of the African Union (AU) which constituted a mediation panel led by *Kofi Annan*, to get the two opposing sides to agree to stop the violence. The *Kofi Annan* led mediation focused on four agenda items namely, the immediate cessation of the violence, addressing the humanitarian crisis, resolution of the political crisis, and examining and addressing the comprehensive constitutional and institutional structures of government, poverty, inequality and historical injustices [92, 94, 95]. This led to the signing of a peace agreement between the two warring factions, and the enactment of the National Accord for Peace and Reconciliation Act 2008. Under this Act, PNU and ODM agreed to form a coalition

government with *Mwai Kibaki* of PNU as president and *Raila Odinga* of ODM as prime minister. The main focus of this coalition government was to immediately address the key historical issues identified under the fourth agenda in the mediation talks, key among them being undertaking a comprehensive constitutional review in the country that would address equity and transparency in public resource allocation, citizens' participation in public governance and other good governance practices [94, 95].

The coalition government embarked on undertaking the constitutional review and in August 2010, the draft constitution was subjected to a public referendum with strong government support. The referendum 'YES' campaign was led by *Mwai Kibaki* and *Raila Odinga*, while a group of ODM politicians, largely from the Rift Valley led by *William Ruto* partnered with church leaders in the 'NO' campaign, opposing some aspects of the draft constitution. The constitution was ultimately passed with 67% approval at the referendum [33, 88].

The 2010 constitution proposed the creation of 47 semi-autonomous counties to be established after the first general election following the constitutional enactment. The respective county governments would have a constitutionally prescribed mandate and functions as described in the fourth schedule (Annex 2) of the 2010 constitution [33].

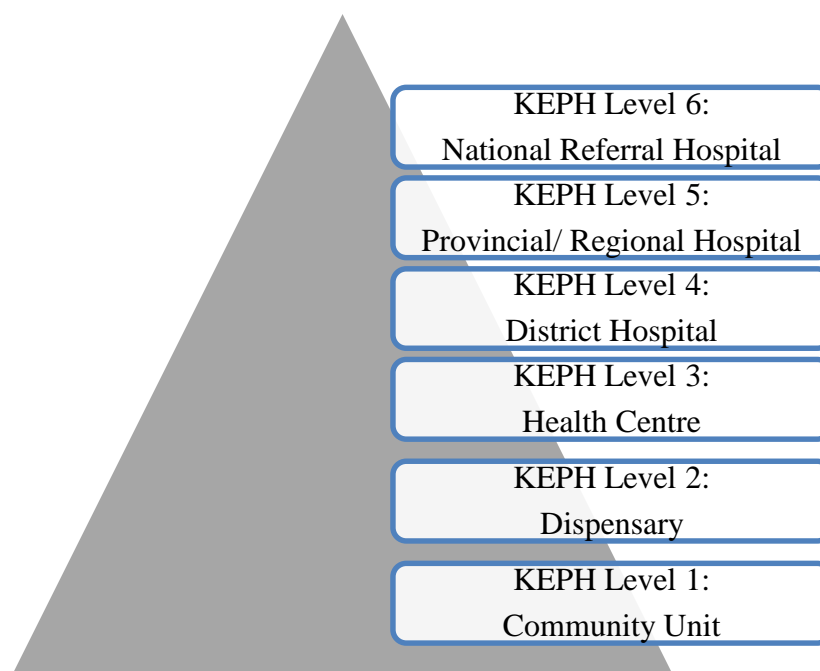
The county governments were to be established after the general elections held in March 2013. However, the transfer of county functions was to happen progressively over a period of three years [86, 96]. This new decentralisation effort in Kenya which is of a devolution nature [9] is largely driven by larger countrywide political processes [86].

### **3.3. Overview of the Kenyan health system**

The government, through the Ministry of Health (MoH), has been both the regulator and major provider of healthcare in Kenya since independence [97, 98]. The government health sector has been undergoing major systems reforms for several decades, including the introduction of user fees in public health facilities in 1989, and the establishment of District Health Management Teams (DHMTs) and District Health Management Boards (DHMBs) [99]. In 2009 the MoH introduced the Health Sector Services Fund (HSSF) which is a system where the government finances some recurrent costs for primary level health facilities, by directly sending monies from National Treasury to health facility bank accounts, without going through the traditional disbursement bureaucracy in the health system [100]. All these reforms over the years led to more involvement of peripheral level ministry structures, and communities in management, planning and coordination of health services [22, 23, 100].

The country's second National Health Sector Strategic Plan (NHSSP2) 2005-2010 defined the Kenya Essential Package for Health (KEPH). The KEPH based strategic priorities and service delivery for the sector on two pillars. The first pillar was a classification of the citizenry into six cohorts namely pregnancy and the new born, early childhood, late childhood, adolescence, adult and the elderly. The second pillar was the organization of health service delivery system into a six-level pyramidal structure of care (Figure 2) [101].

Figure 2: The NHSSP2 KEPH organization of the Kenyan health delivery system



At a coordination level, the health sector has had three tiers similar to that of the wider government arrangement. Until recently after devolution, these coordination tiers have been the ministry headquarters at the national level, the Provincial Health Management Teams (PHMTs) and the District Health Management Teams (DHMTs) [97-102]. The six levels of care, and the coordination levels, were the main sector planning units that undertook operational planning for service delivery, and management and coordination respectively [23]. As part of the coalition government, in 2008 the MoH was split into the Ministry of Medical Services (MoMS) and the Ministry of Public Health and Sanitation (MoPHS), each managed by one side of the coalition government. MoMS was charged with responsibility for curative and rehabilitative health services while MoPHS was charged with preventive health services and health promotion [23, 103].

### **3.4. Planning in the Kenyan health system**

As with many other Sub-Saharan African countries, post-colonial Kenya operated until the mid-90s without a substantive health policy, or strategic or operational plan [21, 97]. The first ‘Kenya Health Policy Framework (KHPF) 1994-2010’ was published in 1994 [98]. To accelerate the realization of the policy vision, the MoH in 1999 published a five-year strategic plan; the ‘National Health Sector Strategic Plan 1 (NHSSP1) 1999-2004’, later followed by the National Health Sector Strategic Plan 2 (NHSSP2) 2005-2010. Both NHSSP1 and NHSSP2 emphasized the prioritization of government health investment towards increasing access to primary health care for all Kenyans [101, 104].

To operationalize the implementation of NHSSP2, the MoH adopted a bottom-up annual planning process dubbed the ‘Annual Operational Planning’ (AoP) process [23, 101]. The AoP process on paper outlined a decentralized planning process within the sector by allowing for priority setting in planning and budgeting to begin from the lowest planning units and aggregated upwards all through to the national level [101]. In practice though, the full realization of the bottom-up planning has been far from achieved as the process has been heavily top-down driven over the years [22, 23, 99]. The AoP planning framework itself only provided the lower level planning units with an opportunity to plan and budget for operational recurrent expenses for delivering and coordinating health services. Until recently after devolution, major budgeting and resource allocation for key sector inputs like employment and deployment of health care workers, purchase and distribution of essential medicines and medical supplies, infrastructure development and major equipment purchase and distribution was retained at national level MoH [23].

After the promulgation of the new constitution in 2010, which coincided with the expiry of KHPF 1994-2010, the health sector began undertaking the development of a new health policy: “The Kenya Health Policy (KHP) 2012-2030”. This new policy laid the framework for both strategic and operational planning in the country up to the year 2030. In line with the requirements of the constitution, the new policy proposed a merger of MoMS and MoPHS back into one MoH, and the creation of a County management and coordination structure for health services [37].

Unlike the previous arrangement, the mandate of the county coordinating unit - in line with the provisions of the new constitution - now includes planning and resource allocation for all health investments including employment and deployment of health care workers, purchase and distribution of essential medicines and medical supplies, infrastructure development and major

equipment purchase and distribution, which were previously undertaken at the national level [33].

### **3.5. Kilifi County**

Kilifi County, which is the study case for this study (ref chapter four) is one of the six counties that formed the former Coast Province at the Kenyan Coast [105]. The Coastal region of Kenya is largely believed to have been the originator of the decentralisation debate in Kenya because the leader of the Kenya African Democratic Union (KADU) which championed for the *Majimbo* federal government system was from the Coast [79, 84]. Over the years the region has consistently been marginalised by post-independence governments leading to recent agitation by some residents for secession from the rest of Kenya [84].

Kilifi County is comprised of the former Kilifi, Malindi and Kaloleni districts. It is headquartered in Kilifi town, with a population of approximately 1.2 million people and covers an area of approximately 12,246 km<sup>2</sup> [105]. It has seven constituencies and 35 electoral wards [77, 105].

### **3.6. Embedded within a ‘learning site’**

I conceived and conducted this study within a broader Health Systems Governance (HSG) research project being conducted at the Kenya Medical Research Institute – Wellcome Trust Research Programme (KEMRI-WTRP) in Kilifi [106], as part of the Department for International Development (UKaid) funded Resilient and Responsive Health Systems (RESYST) consortium [107]. KEMRI-WTRP is one of seven RESYST members, with the consortium’s research organized around three key themes: health financing, health workforce and health systems governance.

The KEMRI-WTRP which is headquartered in Kilifi town, has been in existence in Kilifi for over 25 years, embedded in the main government hospital in the town; the Kilifi County Hospital [106].

The broader HSG project is a ‘learning site’ which is an approach to research where researchers and health managers in a given setting over a long term relationship of continuous interactions and reflections develop specific health system governance questions, and work towards answering them together [72, 108]. There are two other HSG learning sites within the RESYST consortium, both in South Africa [72, 108]. At the time of conducting this study, there were two other studies running within the Kenyan learning site; one focusing on internal and external accountability practices of frontline primary health facility in-charges, and another on priority



setting practices in hospitals. The learning sites work includes regular reflective practice sessions, primarily in Kenya but also across Kenya and South Africa, to deliberate on the data being collected, the 'learning', and the approach. The aim of these reflective sessions is to enhance the collective learning among the diverse researchers involved, and between those researchers and health managers. In so doing the trustworthiness of the data collected and their interpretation is strengthened.

## **Chapter 4: Study Description and Methods**

### **4.0 Overall research question**

How does political decentralization affect sub-national level health sector planning and budgeting?

### **4.1. Purpose and aim of the study**

This was a descriptive exploratory and explanatory study, seeking to examine the goals, design, implementation and implications of political decentralization in Kenya on health sector planning and budgeting at the sub-national level.

### **4.2. Study objectives**

#### **4.2.1. General objective**

To analyse the goals, design, implementation and implications of political decentralization in Kenya on governance and accountability structures and practices for health sector operational planning and budgeting at the sub-national level.

#### **4.2.2. Specific objectives**

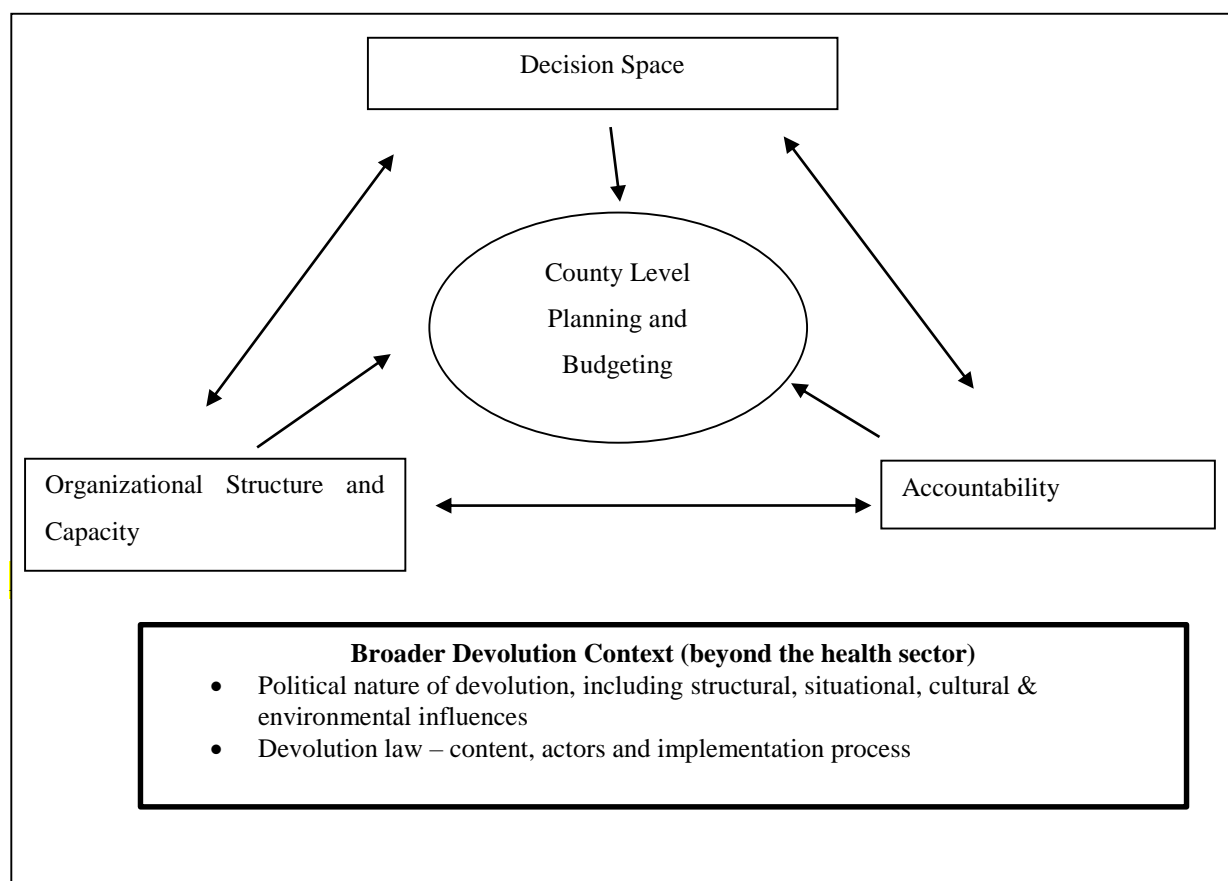
1. To describe and analyse the goals, design and early implementation of political decentralization for health sector operational planning and budgeting
2. To describe and analyse stakeholder expectations and experiences of political decentralization for health sector operational planning and budgeting
3. To draw on the empirical data and literature on good governance and accountability to identify strategies for enhancing achievement of decentralisation goals within the health sector

### **4.3. Conceptual framework**

In this study, I focused mainly on the county level as the focal arena for sub-national level planning and budgeting in the Kenyan health sector under the 2010 constitution. However, I also examined how this level relates and interacts with the national level (above) and the sub-county units (below). I adopted a conceptual framework (Figure 3) that placed the health sector planning and budgeting activities at the county level at the centre; and which interacts with and is influenced by decision space, accountability, organisational structure and capacity in the health sector; and the broader devolution context. Drawing on the literature reviewed (chapter 2), I expected planning and budgeting at the county to be influenced by the public involvement and accountability mechanisms and requirements affecting county health managers, the level of discretion or ‘decision space’ [11] these county level health managers have, and the

individual and organizational capacity of the county health services management unit. I expected all these factors to interact with each other to influence health sector planning and budgeting processes at county level; and to be affected by Kenya's planned political decentralization and its implementation at both national and county level.

*Figure 3: Study conceptual framework*



To apply the study conceptual framework, I drew on several frameworks and theories of decentralization, and on policy analysis literature. To characterize decentralization before and after the implementation of the new constitution, I drew on the original public administration framework [9], as applied in the health sector by Mills et al., (1990) [109]. As described earlier (chapter 2) the public administration framework describes a four-type classification of decentralization models, namely devolution, delegation, de-concentration and privatization. I also borrowed elements of Bossert and Mitchell's (2011) framework; specifically the assertion that within a decentralized system, decision space, or the degree of discretion managers have, is affected by and interacts with institutional capacity and accountability mechanisms of the system [30]. I considered these elements to be important in examining 'what' exactly gets

devolved to the county governments and the ability of the counties to take up the roles transferred to them.

In examining accountability, I was interested in accountability between county health managers and the national MoH; between county health managers and local elected leaders; and between county health managers and the general population directly. I focused on community involvement and participation in the governance of health services, and examined the level of ‘answerability’ and forms of ‘sanctions’ employed by the different health sector stakeholders during planning and budgeting. I utilized the answerability and sanctions elements of the accountability matrix developed by Brinkerhoff. This matrix ranks accountability practices within the health sector by mapping out health sector actors around their capacity to supply information demanded, or sanctions imposed by other actors; against capacity to demand for information or impose sanctions against other health sector actors [18].

To examine and assess the structure and capacity of the county level health system governance structures more broadly, I utilized elements of the organizational capacity assessment criteria developed by UNDP [70] and the Aragon framework as applied by Elloker et al (2013) [71, 72]. This framework proposes that organisations are made of hardware, software tangible, and software intangible capacity elements that are necessary for optimal functioning of the organisations. Hardware elements include infrastructure, technology and finances. Tangible software includes organisation systems and procedures, and management system and procedures. Intangible software elements include communication, relationships, norms and values, and power. I used these criteria to examine the county health sector governance institutions along the hardware, tangible software, and intangible software capacity elements [72].

In examining the broader devolution context I drew from Liechter’s (1994) framework for analysing macro level policy context, which focuses on structural, situational, cultural and environmental factors [69]; and which is described in greater detail in the literature review and discussion chapters. I particularly focused on how these individual elements influenced the design, implementation process and early outcomes of devolution in Kenya. To examine the goals and intentions of the decentralization (content of the decentralization laws), the process of its implementation, and the roles of both national and local level actors I utilized the policy analysis framework described by Walt and Gilson (1994) [68]. In this framework the authors argued that a comprehensive analysis of a policy subject should include a thorough analysis of the content of the policy, the process of its development and/or implementation, and the actors

involved and the policy context [68]. I applied this policy analysis framework to examine the broader context of the planned political decentralization in the Kenya.

I used this conceptual framework largely to inform the development of my data collection tools and to frame my interpretation of the study findings. Subsequently I used it to organise the presentation of my discussion in chapter nine of this thesis.

#### **4.4. Study Design**

I used a case study design. A case study is an empirical investigation of a contemporary phenomenon within a real life context [110]. A case study design is commonly used in situations where the researcher cannot manipulate the actions of the actors involved in relation to the phenomenon being studied, and where contextual conditions are important for shaping the phenomenon [110, 111]. Keen (2006) described case study research designs as being particularly useful when examining planned change within a ‘messy’ real world setting, which the researcher has no control over [111], which is a common characteristic of many policy implementation settings. The main advantage of the case study design is that it allows the phenomenon to be examined from multiple lenses at the same time [110, 112]. Under the case study design, a ‘case’ becomes the unit for analysis. The case in any particular case study is determined by the research questions being explored.

##### **4.4.1. Study case**

In this study, the study case was Kilifi county (described in chapter 3). A county is the sub-national level unit defined by the Constitution of Kenya 2010, to which decentralized functions of government were to be transferred. The constitution created 47 counties in the country, with Kilifi county being one of them. Keen (2006) argues that case selection is particularly important when undertaking policy analysis. Case selection can be done purposively, where cases are typical of the phenomena under investigation, or theoretically, to prove or refute a hypothesis. Whichever approach is used for case selection, the cases selected should ideally have all the characteristics that are perceived to have an effect on the phenomena being investigated [111].

The decision to use one county was to allow for a deeper exploration of the issues under focus within the study. A national level element was also incorporated into the study to identify any issues considered particularly unique to Kilifi County.

I selected Kilifi County as the case for this study because it was the Kenyan HSG learning site for the RESYST consortium, and a county in which I have long term personal experience (see positionality section below). Because of the presence of the learning site, work in Kilifi County will allow for a longer term tracking of the decentralization effects beyond the period of this study.

#### **4.4.2. Study participants**

Participants for this study were largely actors involved in the translation and implementation of the devolved government system within the health sector in Kenya. They were purposively drawn from the national, county, and sub-county level units as outlined in more detail below.

#### **4.4.3. Study tracers**

To allow for an in-depth tracking of the planning and budgeting elements at the county level, I selected three tracers of the planning and budgeting process. These tracers were:

- Overall resource allocation and planning and budgeting for recurrent expenditure
- Human Resources for Health (HRH) management arrangements;
- Essential Medicines and Medical Supplies (EMMS) management arrangements; and

The selection of tracers was informed by findings from an initial document review that showed that these were the largest functions within the health sector to be transferred from the national to county government under the new constitution, and were used to explore and track the health sector planning and budgeting activities at the county level.

### **4.5. Data collection procedures**

Data collection procedures included document reviews, key informant interviews, participant and non-participant observation, and reflective practice. I triangulated data from all these methods.

#### **4.5.1. Document Reviews**

All documents relating to sub-national operational planning and budgeting were accessed and reviewed. These included the Public Finance Management Act 2012, Ministry of Planning and Ministry of Health Planning manuals and guidelines, the draft Kenya Health Sector Strategic Plan 2013-2018, the draft Kilifi County Integrated Development Plan, the draft Kilifi County Health Sector Strategic Plan, and the County Health Sector Annual Work Plan 2013/14.

All documents relating to the design and implementation of the devolved government system generally and within the health sector were also reviewed. These documents included the Constitution of Kenya 2010, and all other subsidiary legislation regarding the decentralization

including the Transition to County Government Act 2012, the National Budget and Revenue Allocation Act 2011, and the Devolution Act 2012. Other documents included the Ministry of Health Position Paper for the Implementation of the 2010 Constitution, the Kenya Health Policy 2012-2030 and the new Kenya Health Sector Strategic Plan 2013-2018, and the Ministry of Health Functional Analysis and Transfer Policy Paper.

The documents were reviewed and content extracted against the study objectives and the conceptual framework.

#### **4.5.2. Key informant interviews**

A total of 26 key informant interviews were carried out with a range of actors involved in health sector planning budgeting and the implementation of the constitution, at national, county and sub-county level. A total of 9 interviews were conducted at national level, 8 interviews at county level and 9 interviews at the three sub-counties within Kilifi County.

National level participants were drawn from the national MoH, Development Partners for Health Kenya (DPHK), the Constitution Implementation Commission (CIC), the Transition Authority (TA), the National Assembly Health Committee, the National Health Workers Union Officials, and UN agencies supporting the health sector in Kenya. County level participants were drawn from the County Department of Health (CDoH) managers, and the County Executive Committee (CEC), Treasury, County Public Services Board (CPSB), Assembly Health Committee, and Transition Authority Coordinators. At the sub-county level, participants were drawn from the Sub-County Health Management Teams (SCHMT) and the County Hospital Management Teams.

At all three levels, sampling was done purposively with the aim of ensuring wide and varied characteristics of participants and viewpoints. Interviews were conducted using interview guides which sought to explore some general issues regarding the intended goals, expectations and effects of the decentralization on health sector planning and budgeting at the county level; and then focused more specifically on issues around the selected tracers. These issues were explored for both before and after the enactment of the 2010 Constitution.

All interviews were conducted in English, tape recorded, and transcribed verbatim. Annex 3 is a copy of the detailed generic interview guides used at the three levels of interviews.

#### **4.5.3. Participant Observation**

During the period of this study, I was actively involved and provided technical support in the development and roll out of several guidelines and manuals for implementing devolution within the health sector, both at national level, and within Kilifi County.

At the national level, I was co-opted into the MoH Functional Analysis and Competency Team (FACT) that was charged with the responsibility for unbundling of health sector functions, assigning them to the national and county levels of government, and developing a policy and plan for the process of implementation/transfer of functions from national level to county level. I was also co-opted as a member of the Health Sector Core Planning Team that was charged with responsibility for developing manuals, tools and guidelines to facilitate planning and budgeting at the national and county level. Furthermore, the team was charged with the responsibility of capacity building county health managers on the county level health sector planning processes.

At Kilifi county level, I was part of the national MoH team that supported Kilifi in the development of the County Health Strategic plan and the County Health Sector Annual Work Plan for 2013/14. Together with colleague researchers at the HSG learning sites, I was involved in regular interactions and engagements with different county and sub-county level health managers in both formal and informal meetings.

I took notes of all my national and county level engagements in the form of a diary.

#### **4.5.4. Non-Participant Observation**

Throughout the data collection period, I undertook non-participant observation for major events and occurrences at the national and county level that were related to, or had an effect on, the implementation of decentralization in the country generally, and within the health sector and Kilifi County more specifically. I did this by routinely and regularly following up debates and discussions in the main national print and electronic media platforms, and by keeping track of unfolding discussions on popular social media platforms.

I maintained a critical events diary for these observations, all through the data collection period.

#### **4.5.5. Reflective practice and learning**

I carried out regular reflective practice and learning sessions with fellow researchers at the Kenya HSG learning site, on several occasions also involving county and sub-county level health managers. These reflective practice sessions were conducted in English, tape recorded and transcribed verbatim. I used the transcriptions during data analysis. A total of 6 reflective practice sessions were carried out at the Kenyan HSG learning site, each lasting between two and six hours.

During the study period, we also held two reflective learning and review meetings with research teams from the two South African learning sites. These meetings – each of four days - focused



on critical reflections on the learning site approach of study. Meeting notes were also kept, which assisted me in the direction of my study and interpretation of my findings.

## **4.6. Data management and analysis**

### **4.6.1. Data management**

All interviews and reflective practice sessions were tape recorded and stored both as notes and on tape during data collection. The tapes were later transcribed verbatim in MS WORD. I made summary notes from all document reviews, and maintained observation notes and diary entries during the observation period. I later imported data into NVivo 9 software to support analysis.

### **4.6.2. Data analysis**

During data collection I used information generated from document reviews and initial interviews to refine subsequent interview guides. This allowed for deeper exploration of emerging themes.

I used a ‘framework analysis approach’ as described by Pope et al. (2007) for data analysis. This approach is useful for policy analysis research where there are very clear themes around the study objectives and conceptual framework for which data are needed. It is relatively structured with clear steps, but also allows for new ideas and themes to emerge over the course of the research as is standard with qualitative research approaches [113].

Using this approach, I first undertook data familiarisation by reading through the summary notes, listening to tapes and going through all the transcripts. I developed an initial thematic framework drawing on the study objectives, the conceptual framework and from themes emerging organically from the data familiarisation. I then developed an initial coding tree which I used for trial coding. I cross-checked and refined the initial coding tree with the HSG learning sites colleagues and with some key informants. I subsequently used the refined framework to code the entire data set. I later organised and arranged coded sections of the data into thematic charts related to key themes in the thematic framework. Annex 4 is a copy of the thematic frame developed during data analysis

## **4.7. Validity and reliability**

All data collection tools were shared and cross-checked with other researchers and colleagues across the three learning sites in Kilifi and South Africa. To enhance the validity and reliability of findings during data collection and analysis, a number of techniques recommended by Mays and Pope [114] were employed. These included;

*Triangulation:* As noted above, I employed different data collection methods including document reviews, interviews and varying forms of observations, with each method having particular strengths and contributions.

*Reflexivity:* I was constantly reflecting on my personal and epistemological position, critically appraising how my own values, beliefs and experiences – as well as the study design and conduct of the research – might influence data collection, analysis and interpretation of findings (discussed in more detail below). Other researchers at the HSG learning sites supported this process in our reflective practice sessions.

*Participant validation:* I regularly shared data collected and initial analysis themes both formally and informally with different health managers and key informants at both county and national level, for their feedback and to gather further information. This clarified my research aims and deepened my understanding.

*Fair dealing:* I deliberately and consciously selected a wide and broad range of participants to ensure coverage of a wide range of views and perspectives of respondents.

#### **4.8. My personal positionality**

It is always important for any researcher undertaking qualitative research work to be cautiously aware of their positionality and continuously reflect upon it. The discussion about ‘insider’ and ‘outsider’ positions in qualitative research has been the subject of continuous debate [115, 116]. Insiders have been argued to have easy and better access to quality data because of the tacit knowledge they possess, but it has also been argued that they tend to be inherently biased. On the other hand, outsiders lack the tacit knowledge, but have the advantage of curiosity with the ‘un-familiar’ [115]. Walt et al (2008) argued that in health policy analysis, the way researchers are viewed both as individuals and as the institutions they represent by their research participants will have an impact on their research process [75]. This is arguably particularly the case when the researcher is required to engage with high level policy elites [117]. The researcher’s position in health policy analysis therefore can have an important impact on both the way data are collected and the way they are interpreted [75].

In respect to familiarity with Kenya and the Kenyan health sector, between 2006 and 2009 I worked as a District Medical Officer of Health (DMoH) in Kilifi, where I was involved in managing and coordinating health sector planning and budgeting at a district level [23]. As part of my DrPH training, I conducted my DrPH Organizational and Policy Analysis (OPA) project at the Ministry of Health headquarters where I was studying the process and influences of health sector operational planning and budgeting at the national level [23]. During my OPA

attachment at the planning departments in the MoH headquarters I was actively involved in the development of the planning templates and guidelines for the different planning units. I was also involved in other processes and activities that were going on at the time including the development of a new health policy and new health sector strategic plan, in line with the new constitution. It was because of this involvement with the national MoH that I was co-opted to provide technical assistance into the MoH Functional Analysis and Competency Team (FACT). The FACT was charged with the responsibility of unbundling the MoH functions and assigning them between the county and national level of governments as envisaged in the 2010 constitution, and with coming up with an implementation plan for the transfer of the functions assigned to the county level. I was also co-opted into the national level MoH Technical Working Group (TWG) for policy and planning. At Kilifi county level, I have been providing constant technical assistance on planning processes to the county and sub-county health managers.

I believe that my previous experience in the health sector, my current engagement with the MoH at county and national level, and my training and affiliations with the London School of Hygiene and Tropical Medicine (LSHTM) and the KEMRI-WRTP in Kenya provided me with a unique combination of tacit knowledge about the health system in Kenya, and institutional legitimacy, both of which have been argued to be important in policy analysis research [75]. However as noted above, I have had to constantly monitor and reflect on my different roles; and their influences on the data collection and its interpretation with other colleagues. Overall, I believe the close collaboration with colleagues working within the RESYST learning sites both in Kenya and in South Africa provided me with an important and unique blend of ‘outsider’ and ‘insider’ positions in enriching this study.

#### **4.9. Ethical considerations**

Ethical review and approval for this work was obtained from both the LSHTM (LSHTM ethics re: 6250) and the KEMRI (Ref: KEMRI/Res/7/3/1) ethical review committees (annex 5). There were no direct anticipated risks for any participants, apart from time spent during participation in the interviews. A comprehensive information sheet highlighting study background and aims was given to all potential participants. A formal informed written consent (annex 6) was obtained from all participants selected to participate in the interviews. To protect confidentiality, all personal identifiers of the participants were removed from the tapes, transcripts and analysed reports.

#### **4.10. Summary**

In summary, I designed this study as a ‘case study’ for examining the effects of political decentralisation in Kenya on sub-national level planning and budgeting. I developed and utilised a conceptual framework that borrowed from several decentralisation and policy analysis frameworks, and that was informed by initial inquiry from document reviews and discussions with key stakeholders. I employed several qualitative data collections methods including document reviews, participant and non-participant observations, key informant interviews and reflective practice. I used the thematic framework approach for data analysis. The study received ethical approval from both the LSHTM and KEMRI ethical review committees.

Finally, guided by my study objectives and the study tracers, I have organised my results into four chapters. After an initial chapter reporting on the broader political context of devolution, the remaining results are organised by the three study tracers. In the Discussion I return to each element of the conceptual framework in turn, drawing on the findings from all three tracers.

## **Chapter 5: Broader Context of Devolution in Kenya**

### **5.0. Introduction**

In this chapter I present findings on the broader context of the early days' implementation of devolution in Kenya, which is an important background to the subsequent results chapters which focus specifically on the health sector. The chapter largely focuses on the broader political context around the early days' implementation of devolution, after the 2013 general elections, how this context links with the country's political history described in chapter 3; and how all this influenced the health sector effects of the early days' implementation of devolution. This chapter draws largely from the content and description of devolution in the 2010 constitution and other relevant subsidiary legislations; and data gathered on the country's political environment during the early days of implementation of devolution (post 2013). I begin with an overview of the overall and health sector goals of devolution, including the perceptions and expectations of different stakeholders. I then describe the early implementation experiences and outcomes of devolution.

For this chapter, I have drawn data largely from the document reviews, key informant interviews and general observations, as well as from published literature.

### **5.1. Overall and health specific goals of devolution in Kenya**

#### **5.1.1. Stated, expected and perceived devolution goals for the health sector**

The 2010 constitution did not have any stated health sector specific devolution goals. This is partly because the constitution review and drafting was influenced by the broader political contests over general public resource allocations and management, rather than delivery of specific government services [33, 86] and partly because health sector actors did not play a very active role in the constitutional review process and the actual drafting of the devolution laws. The apparent lack of interest and active participation of health sector actors was perhaps surprising, considering that for several decades, health sector reforms in the country had deliberately focused on decentralizing certain responsibilities including supervision, planning, budgeting and overall coordination of health service delivery to the former district level [23, 118, 119]. One might have thus expected the health sector to actively embrace the devolution debate and concretize the goals and gains of health sector decentralization in the country.

From the observations during the early days of implementation of the county governments, the health sector seemed to be playing a catch-up role in coping with the rapid implementation of the devolved government. Together with significant changes to the roles and power balance

between national MoH and the counties [33, 86, 120, 121] this led to interviewees reporting that the national MoH felt uncomfortable and reluctant to facilitate - and even blocked - the smooth transfer of health sector functions to counties.

[...What is important for the health sector, and I think where they missed the boat was during the constitution making process. What is left now is to just simply define what are our (national MoH) medium term goals and irrespective of what's happening in this political arena, and we keep an eye on those goals...] KII 004

[...the health sector itself we had been grown into a particular system of doing things and we have to change and the change is so drastic that we have to do things completely different, now that is shocking us and that is what is causing all this slow response to changes and acceptance for the devolution to take place and in fact we have even closed ourselves not even to do it now, we have tuned ourselves to argue that now it (health sector devolution) can't work...] KII N 003

In the allocation of functions between the two levels of government, however, the constitution did state that the national MoH would be allocated health policy and standards development, capacity building and national health referral services functions; while all day to day health service delivery functions including construction of health facilities, procurement of commodities and management of health workers would be devolved to counties (annex 2). As in other sectors with devolved functions, the national MoH was to work with the Transition Authority (TA) to develop subsidiary legislations, policies and plans to facilitate the distribution of health sector functions between national and county government. Nevertheless, from observations and interviews it was clear that senior MoH leaders at the time were not very keen to develop these policies and plans, and only started the process once political pressure was put on the national government by counties.

[...they (national MoH) were forced ... they were being harassed in the newspapers every day. So it was under duress: You think about it, when we were working on the FACT (MoH Functional Analysis and Transfer) Policy. .... It was only Shariff (one of the MoH directors) who supported it. The rest of the ministry was saying, ah, those crazy people who don't know what they're doing, and they ignored the process....] KII 004

### **5.1.2. Overall stated, expected and perceived goals of devolution**

Given that there were no health sector specific devolution goals, it is important to understand the broader goals of devolution the health sector was expected to be part of, and that strongly influenced how devolution was implemented and its effects in the health sector. The 2010

constitution clearly highlighted several key principles and objects of devolution [33, 34]. These include:

- Promotion of democratic and accountable use of state power
- Fostering national unity by recognising diversity of the Kenyan people
- Giving power of self-governance to the people of Kenya so as to enhance their participation in the exercise of state affairs in decision making
- Acknowledging and recognising the right of communities to manage their own affairs and further their development
- Protecting and promoting the interests and rights of marginalised communities
- Promoting social and economic development and the provision of easily accessible public services closer to the people
- Ensuring equitable sharing of national and local resources throughout the country
- Facilitating the decentralisation of state organs and their services closer to the people
- Enhancing separation of state powers and to promote checks and balances in the management of public affairs

Beyond what was stated in the constitution, data from my study suggest that key expectations of devolution were: 1) inclusion and participation of all communities in public governance processes; 2) addressing real and perceived marginalisation of certain areas through more equitable public resource allocation; and 3) enhancing bottom-up approaches in priority setting and planning for governed resources.

Regarding the first expectation of devolution, early decentralization models and policies by the government including *Majimboism* at independence, local authorities from the 1970s, and the DRFD in the 1980s did not achieve much towards this effort [80, 86, 122]. Thus citizens continued to push for a devolved government system and to entrench community participation in public governance within the constitution [86, 123]:

[...You know, if you look at article 174 and you will see the objectives of devolution. but by and large people now wanted to make sure that you know when you say that people are on the driver's seat when it comes to development that it is actually true.....] KII N 001

The equity expectation was in response to concerns about past governments' actions. The first national post-independence long-term government strategic economic development policy document zoned the country into high, medium and low economic productive areas based on

population density, agricultural productivity and proximity to the country's only Mombasa-Nairobi-Kisumu railway-line. Under this strategic plan, government development investment was to be prioritized along the targeted high priority areas [85], leading to certain regions in the country being neglected from government resource investment, and feelings of discrimination and disenfranchisement [86, 121].

[.....in fact the greatest problems in Kenya are as result of either real or perceived inequalities in the society and the therefore discussions around the change of the constitution .....it was always about how can more people in Kenya in particular, how can more communities feel like they are also a part of Kenya .....] KII N 005

Subsequent post-independence central governments continued to adopt policies and patronage practices perceived to be oppressive and marginalizing of some communities [86, 120]. 'Eating' - or allocation of resources – was regularly reported to be a preserve of regions and communities those in power came from. Some analysts have argued the strong push for devolution actually came from a view that it should be everybody's turn to 'eat' [86, 93]; a view also expressed by some interviewees.

[....Because previously under de-concentration and even more specifically you know Moi's regime, even when you say people are at the driver's seat of development, if a region was seen to be developing faster than others, that was a problem. And if a particular region was, did not did not sing to the tune or did not subscribe to the political ideology of the ruling class of the day, then it was ignored.....] KII N 001

[....I think the issue is a lot of Kenyans felt that they were marginalized with the centralized policy so they voted for a constitution which empowered them, I think that was the main thing.....] KII N 006

Perceptions of institutionalised marginalisation and discrimination in government resource allocation [86, 121] contributed to strong support for the establishment in the constitution of a minimum amount of government revenue to be unconditionally allocated to all counties in an equitable manner, and an equalisation fund for historically marginalised counties [33, 86, 124]:

[..... the clamor for constitution review of Kenya have been mainly driven by the urge to ensure equality and equity in distribution of resources, equality and equity of sharing of power and the in fact the greatest problems in Kenya are as result of either real or perceived inequalities in the society.....] KII N 005

[....You know previously, you had a budget, people at the central level here determined how much goes to the districts, but now we have legislation that the constitution requires



that at least 15 percent of the national revenue should you know go to the county, this has created some equity....] KII N 001

Regarding the expectation of enhanced bottom up approaches to priority setting and planning under devolution, under previous government systems, district planning was heavily dictated by central government through prescriptive planning formats and resource allocation criteria [23, 80]. Districts did not have much discretion to include local priorities into the plans and no flexibility on how to spend the centrally allocated funds [80]. Under devolution, the constitution stated that government resources allocated to counties as part of the equitable share are discretionary [33, 86]. Central government therefore has minimal control over how counties allocate their resources; and counties have full control over the prioritization for the use of these funds based on local priority needs. This was echoed by several interview participants.

[...And I think the other difference is that I think under the old system there was very little discretionary funding. So you really have a committee that is sitting to decide on priorities for money they do not even have. So that's really the difference. ...] KII N 001

[.....So it leaves the county the freedom to look and say okay, this plan (the National health strategic plan) says ABCD but we're only going for A and C, you know. They're quite free and it gives them a lot of flexibility....] KII N 004

However some of the interview participants felt that the constitutional unconditional allocation to counties was not a good idea as it would be difficult to make county governments adhere to national guidelines and allocate resources along universal national priority target areas, and that national priorities would be undermined.

[....The biggest mistake, one of the biggest mistakes of the constitution in my view was to create devolved units without conditions. Okay you provide funding without conditions. Devolved units grants have to be conditional to ensure adherence to national priorities....] KII N 003

## **5.2. Proposed structure and implementation of the county governments**

### **5.2.1. Establishment of institutions to facilitate transfer of functions to counties**

The constitution envisaged a seven year implementation phase for establishing the County governments, running from August 2010 [33, 125]. This was to have a two-year preparatory phase for establishing relevant government support structures, a three-year transition period for transfer of functions to counties, and a two year period for evaluating the implementation. The

initial two year period prior to the general election was for parliament to enact the required subsidiary legislations that would allow for the establishment of key institutions that would assist in the preparation for the establishment of county governments [34, 125]. Part of the subsidiary legislation was to include the Commission of Implementation of the Constitution (CIC) Act which created the CIC to oversee the constitutional implementation process [126].

Another key legislation was the Transition to Devolved Governments Act 2012, which was meant to provide the legal and institutional framework for coordinating the transfer of functions to devolved governments while ensuring continued public service provision. This Act provided for the formation of the Transition Authority (TA) to oversee this role.

Once established, the TA was to work with all relevant national government ministries with earmarked devolved functions to undertake a functional analysis and allocation between the two levels of government; and then develop a transition implementation plan. The MoH for example developed a three-year implementation plan for the process of transferring devolved health sector functions to county level. The proposed plan was to begin by developing guidelines for the structure of a County Health System, and establish and build capacity for the structures that support the county health systems before eventual transfer of devolved health sector functions [125].

### **5.2.2. Structure of the county governments**

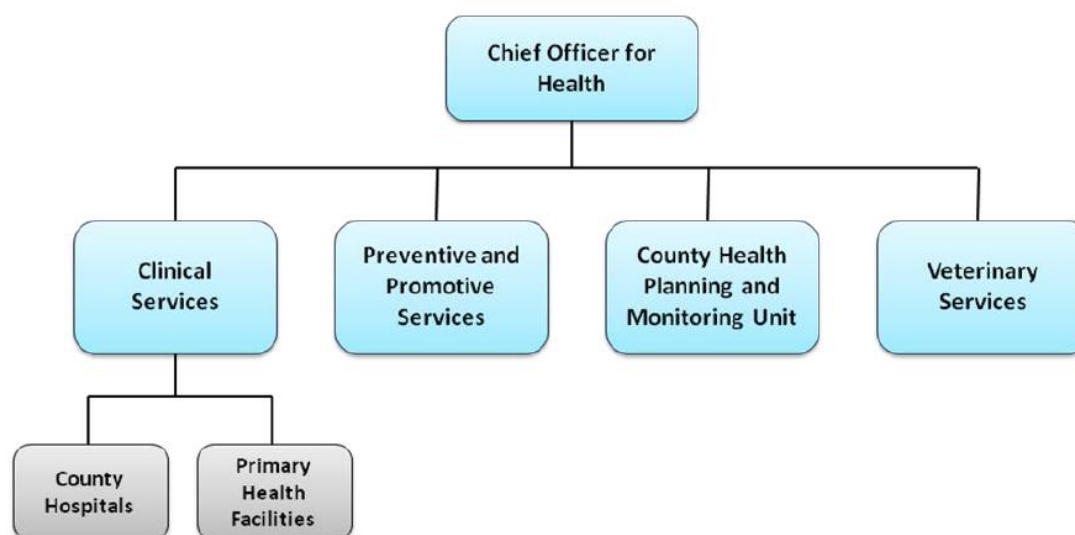
The constitution established a county government to be made of two arms. A County Executive arm made of an elected County Governor and Deputy Governor; and a 10 member County Executive Committee (CEC) appointed by the governor and approved by the County Assembly [33, 34]. The CEC members have overall policy and political responsibility over each of the ten County Departments. The County Department of Health (CDoH), headed by the CEC Health, is established as one of the 10 county departments under this law. Within each department and working under the CEC member is a Chief Officer, also appointed directly by the governor with approval from the county Assembly, who has the overall accounting and administrative responsibility over the respective department [34].

The second county government arm legislature is the County Assembly made of elected Members of County Assembly (MCAs) representing each electoral ward in the county, as well as some MCAs nominated by political parties in the assembly to represent special groups.

Within the CDoH, the MoH FACT policy document proposed an organization of the senior CDoH top management structure, to be known as the County Health Management Team (CHMT), under the Chief Officer Health (Figure 4 below). The document also highlighted that

counties further decentralize their functions by establishing Sub-County Health Management Teams (SCHMTs) for coordination and management of primary health services, and Hospital Management Teams (HMTs) for management of county referral hospitals. The nature and number of the units were to be based on county specific needs [127].

*Figure 4: Proposed CHMT structure of the CDoH*



*Source MoH FACT Policy page 24*

### **5.3. Early implementation experiences, outcomes and their key influences**

This section describes the early implementation process, experiences and outcomes of the devolved government system in Kenya and key influences on this process. Data in this section are largely drawn from observations and interviews.

#### **5.3.1. Establishment and functioning of sector working groups**

When it was constituted the TA established sector specific technical working groups referred to as Functional Analysis and Competency Teams (FACTs). These teams were comprised of TA commissioners and respective ministry staff. The mandates of the FACT teams were to 1) undertake a detailed analysis of the ministry functions 2) undertake a skills and competency analysis at national and county levels and 3) develop policy strategy for functional assignment and transfer of the respective ministry functions.

As with other ministries, the MoH established a FACT working group in which I was coopted as a member. The MoH FACT team developed the MoH FACT Policy document including an elaborate 3 year roll-out plan of the health sector devolution. However, some interviewees felt

that in the absence of county government representation in the TA and MoH FACT team, some county level functions were assigned to the national MoH.

[...The county governments were not in place when the FACT was established, so when the county governments came into place, the national government FACT had already unbundled the functions; and unbundled them conservatively and in fact retained a lot of functions that had been allocated to the county governments...] KII N 003

Because both the composition of the TA and the sector specific FACTs was heavily dominated by national government representatives, the county governments once established, were very sceptical about their proposals, claiming that these entities either deliberately retained some constitutionally identified county functions at national level, or proposed a deliberate slow and delayed proposes or transferring county level functions.

### **5.3.2. Delay in establishing the CIC and TA**

Soon after the promulgation of the new constitution in August 2010, the then PNU and ODM coalition government continued to be faced by internal wrangles and disagreements over the constitution implementation process. These wrangles significantly delayed the constitutional implementation process ahead of the general elections, specifically affecting the time-lines for the establishment of key institutions that would be required to prepare the structures and capacity for the county governments.

Notable among these delays was the enactment of several subsidiary legislations and formation of constitutional bodies including the CIC and the TA that were needed to oversee the constitutional implementation and implementation of the devolved governments system. When it was finally established, the TA was comprised of independently appointed commissioners, but also co-opted Principal Secretaries of eight national government ministries, which had been identified to have most devolved functions [125]. This composition of the TA led to it being perceived by county governments as a National Government institution.

The delay in establishment of the TA coupled with its structural challenges meant that it was unable to fully undertake its function of establishing all required county structures, and building the required capacity to enable them take up their functions after the elections. This led to several key stakeholders accusing it of being deliberately unsupportive of the counties; with others, particularly from the counties calling for its disbandment.

[...I'm one of the proponents of disbanding TA and I have told TA. The reason is one; TA is actually an organ of national government. It has not in any way taken on board counties. ... the only thing they can do is to want to control the counties....] KII C 002

### 5.3.3. Influence of wider political battles

The delays in establishing legislations and constitutional bodies were related to wider on-going political battles. Ahead of the first general election under the new constitution, the International Criminal Court (ICC) opened a case against six Kenyans perceived to have had overall responsibility over the 2007/08 post-election violence in the country [93, 123, 128]. Key among the six were Uhuru Kenyatta and William Ruto. The ICC cases became a turning point in the political arena as Uhuru Kenyatta and William Ruto joined together to form a political coalition, dubbed the *Jubilee Coalition*, which quickly gained popularity especially among the populous Kikuyu and Kalenjin communities. These leaders accused their opponents - the Coalition for Reforms and Democracy (CORD) coalition – of plotting to have them prosecuted at the ICC, to prevent them participating in the election [93, 129].

From the observation of the election campaign period, the CORD group argued that if Kenyans voted for the *Jubilee Coalition*, the hopes of the constitutional implementation, especially regarding devolution, would be lost. This they argued was because, Uhuru Kenyatta, who was the *Jubilee* presidential candidate was for many years in KANU and that KANU had always been seen to oppose any reforms. CORD further argued that William Ruto who was Uhuru's running mate had been the leader of the 'NO' campaign during the 2010 constitutional referendum, and thus could not be trusted to implement a constitution which he had openly opposed during the referendum.

In the general election held in March 2013 the *Jubilee coalition* won the presidency, and with an absolute majority in both the senate and national assembly. The CORD coalition however won more governors' positions giving it a majority representation in the Council of Governors (CoG) [93]. Following the perception of the many years of marginalization within the region, and the linking of the *Jubilee coalition* with this marginalization, the Coast region including Kilifi County voted predominantly for the CORD coalition [122]. The perception of the *Jubilee Coalition* being against devolution continued after the election and was expressed by some of the participants in the interviews;

[..... the current (Jubilee) government is of people who were actually in the previous governments and it is actually these people that were seen as marginalizing others....]

KII C 002

[...I think the people who have really pushed for decentralization are not the ones who are currently implementing. Alright, in fact people who are implementing this constitution are the very people who opposed it so you can imagine. They are making

Kenyans think that they believe in this document when in the first place they opposed it...] KII C 007

CORD protested the outcome of the presidential election by petitioning the results at the Supreme Court. The petition was eventually dismissed by the court, but this caused a delay in the swearing in of the president and his deputy. However, owing to the presidential election petition, the county governors were sworn in and county governments established before the president had been sworn in, and national government established.

[...the elections were in March but you will realize okay the county governments came into effect much earlier. The governors were sworn in then the president. Right because of the court case and ... so some of these governors were sworn in and the president was sworn in later on by then of course the cabinet was appointed a little bit later so the issue of the delays in everything also delayed the preparations right...] KII N 006

From the observations, the early days following the general elections witnessed a lot of political activities characterized by ‘political deal-making’ by the different political players as a way of arriving at a compromise and consensus over contentious issues in the implementation of devolution. Many times these ‘political deals’ went against the prescribed process of which devolution was to be implemented.

Several respondents during the interviews also noted that the political activity going on in the country at that time had over-shadowed the envisaged technical implementation process of the constitution. Some respondents however argued that devolution is actually a political process about power and control of resources and should always be viewed in that light.

[...everything, the entire process of devolution and transition is political not only political because of political parties but even interested parties. For instance .... I don’t know whether you are going to ask me a question about the challenges we are facing. We are seeing that the institution that is supposed to support the process; the Transition Authority, is literary actually obstructing it (the devolution implementation process)...] KII N 008

[...The challenges which we’re facing is that we’re approaching devolution as a technical process and yet it’s the political process, that’s the problem which we’re having. It is not a technical process; it is about power, the exercise of power that is politics, pure and simple. So you’re using technical tools [laughter] to understand the political process, you will never understand them...] KII N 004

#### **5.3.4. Politically motivated fast tracked transfer of functions**

Considering that they were sworn in first, owing to the ongoing presidential election petition, some of the governors began to establish their county government before the president and his deputy had established the national government. Soon after, the county governors through their CoG began to pile political pressure on the national government for immediate transfer of all functions earmarked for county governments. They went ahead to accuse the national government of being ‘anti-devolution’. This pressure prompted the president to convene a meeting with the CoG under the constitutionally established ‘Summit’, which is a consultative structure that brings together the president, his deputy and the CoG. After this first Summit meeting in June 2013 the president publicly directed the TA and the national Ministry of Planning and Devolution to work with all government ministries and ensure that all functions earmarked for counties are devolved immediately. This directive disregarded the planned three year phased transfer of functions, and was seen by many stakeholders as one meant to appease the political interests at the expense of the technical viability.

[...there were arguments that the government, is anti-devolution and to be seen not to be anti-devolution we said yes, these services must be transferred and that is it. The functions were transferred....] KII N 002

[...But because you realize that politics overrides rationality, a lot of these functions that you know, you remember there is a time the governors went to the president and demanded for these functions and the president said that these functions should be transferred immediately...] KII N 001

Several stakeholders and commentators had varied views on the presidential directive. Some had concerns that the county governments had not yet fully set up their structures and thus did not have the required capacity to undertake the functions being transferred, while others felt that the president actually agreed to this hurried transfer of functions because he wanted the counties to fail and be portrayed in bad light, and in the process frustrate devolution.

The politically motivated fast-tracked process of transfer of functions caused a lot of fear and anxiety among many senior national government technocrats because of the uncertainties it presented them. This led to some resistance to transfer, or at times sabotaging the process of transfer by not providing adequate support and capacity for the counties to take up the functions as envisaged.

[....It is (the resistance to transfer functions) deliberate. It's not ignorance. Because you're coming from a unitary system and the unitary system will fight back any attempt to devolve power...] KII N 004

This hurried transfer of functions led to a significant disruption in government services particularly in health, and this was also reported by most of the interview participants, particularly at the Sub-County level.

[....But right now it's chaos, over 5 dispensaries in (X Sub-County) now don't have water, I don't know where to get money to get to buy water for them. They don't have money they don't have water. Initially they used to receive water from the ministry of water. Before devolution, ministry of water used to get funds from the drought mitigation program then we just make a call and given them a schedule for every Monday they used to supply us water throughout the health facility but now they don't have that funding anymore...] KII SC 006

#### **5.3.5. Political power battles**

The above situation illustrates that shortly after the general elections, power battles dominated the national political debate about devolution. These political debates overshadowed the rationality needed to undertake the implementation of the devolved government structures and smooth transfer of functions. A case in point was immediately after they had been sworn into office the County Governors demanded to use the title '*His Excellency*' and fly the '*national flag*' on their official vehicles. This triggered an extended national debate on the political power pecking order. In what was largely seen as an attempt by parliament to punish the governors, the senate enacted a law to define the political pecking order ranking the governors below the senators, and went ahead to initiate impeachment process for several governors within the first year in office. This the senate did at the expense of focusing on supporting pending legislation that required to be enacted to facilitate the implementation of devolution. Figure 5 below illustrates the ongoing political power battles at the time as covered by a section of the local media in the country.



Figure 5: Newspaper articles illustrating the political power battles in the country in 2013



In Kilifi County, the county government bought a luxurious multi-million-shilling official residence for the county governor shortly after the elections, at a time when the county hadn't fully set up its structures, and was thus having challenges in implementing projects and providing essential services. The county further went ahead to buy expensive four-wheel drive vehicles for its CECs members. It was also observed and reported that the governor frequently used a helicopter to fly to the office from Mombasa where he actually lived, even after buying this very expensive house. This attracted wide-spread criticism in the mainstream national media and social media, and at some point the governor was summoned and interrogated by the Nation Ethics and Anticorruption Commission. Nevertheless, his decisions did not attract as much criticism by the local Kilifi citizens. A section of local citizens in fact defended the governor's move arguing that these type of state privileges had for a long time been a preserve for those in power in Nairobi, and thus it was ok for one of their own to also enjoy these [86, 121].

Figure 6 below is an illustration of some of the ongoing media debate on the Kilifi county governor decisions at the time.

Figure 6: Illustration of power manifestation in Kilifi County

The collage illustrates the public scrutiny and media coverage surrounding the Kilifi governor's house deal. It features a newspaper clipping where the governor defends a Sh145m house deal, a photo of the beachfront house, a social media post from Boniface Mwangi mentioning a Sh4 million purchase for food, a 'Citizen Weekly' article about the governor's chopper, and a 'NATION MEDIA GROUP' article where the Kilifi secretary defends the governor's multi-million home.

### 5.3.6. General public involvement and accountability in the governance process

The new constitution brought about several requirements for public participation and accountability in governance processes [33, 35]. An example was in the process of appointment of senior public officials in both the national and county governments. As observed at the time, the president and his deputy nominated the candidates to senior government offices, including cabinet secretaries and principal secretaries. The nominated candidates then went through a public vetting process in parliament where members of the public were allowed to present any issues they had in support of, or against the nominated individuals, and after considering the issues raised, parliament debated and either approved or rejected the nominated candidates. The president then only substantively appointed these officials once they had been approved by parliament.

Similarly, from observation at the county level, the governors also nominated candidates for senior county government position as required by law. These were later subjected to public vetting at the County Assembly before being appointed into office. Another observed example of public involvement was in the deliberate efforts to engage and consult with the public and other stakeholders during the development of the first county government budget.

In addition to such direct community and stakeholder participation, county assemblies were established by the constitution as the main formal community representation accountability

structures at the county level. In Kilifi, a number of the interview participants felt that the County Assembly was unable to appropriately play this role because of lack of skills and capacity.

[...The County Assembly for me is a body which has the will and the power to do things right but has no capacity to do it, but they have the power, they have the everything, the will and everything but the capacity is very limited because for you to have, to hold me accountable, you should be analytical. You should be a person who can understand things to a certain level...] KII C 002

[...Yes.... When they're (members of county assembly) given these documents, they don't read them. Currently the CIDP (County Integrated Development Plan) in their hands, they have not been able to pass it because nobody seems to know how to move it because the complexity and they do not understand. They have no idea where to start...] KII C 003

Because of this lack of capacity at the County Assembly level, there was a view that the executive could easily buy their way from the Assembly if they need any decision to be made; thus weakening public participation and accountability in the governance processes.

[.... You see. So public participation is very weak, very very weak because when you bring that Bill, you bring them here to take them through ... you actually invite the committee to take them through the Bill. Pay them a sitting allowance; When they get it there at the assembly, they will not raise a finger on it....] KII C 002

## **5.4. Summary**

In summary, the push and design for devolved government structure in Kenya did not have health sector specific goals, but was rather driven by a political goal of ensuring equitable distribution of government resources across the different regions in the country, among other political goals. To this end, the constitution designed a two-tier government system with a national government made up of an executive, legislature and judiciary; and a county government comprising of an executive and legislature. Both tiers are directly elected by the people and are accountable to the people both directly and through elected representatives, for functions allocated to them.

There was a well laid down plan for the establishment of county government structures and phased out transfer of functions from national to county governments. However, political power struggles and mistrust during the early days led to a hurried transfer of functions to counties before appropriate structures had been established and their capacity built. This led to

major disruption in all government service delivery, and particularly in health. The process of establishment of both national and county government did encourage greater public involvement and participation than in the past, in particular through the public vetting of nominated senior government officers before they were formerly appointed into office. In the next three chapters, I present findings on how this broader context affected the implementation of devolved government systems in Kenya around the three health sector study tracers.

## **Chapter 6: Planning and Budgeting Under Devolution**

### **6.0. Introduction**

In this chapter I begin by describing how government resources should officially be allocated to counties and health services and how the county level health sector should undertake planning, budgeting and financial management for recurrent resources. I then describe the early experiences of these processes in the County Department of Health (CDoH) in Kilifi County. I draw on my document review, key informant interviews, and participant and non-participant observations.

### **6.1. How government resource allocation, planning and budgeting should work**

#### **6.1.1. Overall national government planning and budgeting structures and processes**

The 2010 constitution established four mechanisms within which counties get resourced: (i.) the equitable unconditional share from national government set at a minimum of fifteen percent of all national government revenue; (ii.) an equalisation fund allocated to marginalised counties to provide specific social services, set at a minimum of one half percent of national government revenue; (iii.) local revenue generated within the county through levying specific county level taxes; and (iv.) conditional grants given by national government to counties to address specific national strategic priority issues.

A national Commission for Revenue Allocation (CRA) was established in 2011 to develop a Resource Allocation Criteria (RAC) to allocate the equitable share and the equalisation fund to counties. A Public Finance Management (PFM) Act elaborates the government budgeting process including key events and specific time lines at national and county level (Table 2).

In brief, the national government once elected is supposed to outline its five year Medium Term Plan (MTP), from which Treasury draws the proposed annual government budgets in a revolving manner using the Medium Term Expenditure Framework (MTEF) budgeting process. The Cabinet Secretary for Treasury should present the proposed government budget to the Parliamentary Budget Committee by the end of April, including allocations to all the 47 counties. Thereafter the committee should publish the budget, invite public and stakeholder comment, consider those inputs, and then present the budget to parliament for approval by the end of June.

Table 2: Summary of key events and timelines in the government budget process

Key event	Time line	Responsible Person/Institution	Comments
Elaboration of newly elected government five-year Medium Term Plan (MTP)	End of first September after the election	National Treasury	New government aligns its campaign manifesto with the Kenya Vision 2030 National long-term strategic development plan
Publishing of budget guidelines to all government entities	30th August each year	Treasury Cabinet secretary	Guidelines outline respective year's priorities and sets broad ceilings for government entities e.g. ceilings on allocations between recurrent and development expenses. Guidelines will be used by controller of budgets to appraise budgets from all government entities.
Submission of Budget Review and Outlook Paper (BROP) to cabinet for approval	30th September each year	Treasury Cabinet secretary	Outlines government budgetary performance for previous financial year and presents government projected revenue for coming financial year, providing indicative allocations to all government sectors including county governments
Submission of annual budget policy statement to parliament for approval	15th February each year	Treasury Cabinet secretary	Policy statement outlines broad national strategic priority goals which national and county government entities should align their budgets to.
Submission of government budget estimates to parliament budget committee	30th April each year	Treasury Cabinet secretary	National assembly scrutinises allocations to national government entities in-line with governed strategic priorities. Senate scrutinises allocations to county governments in-line with constitutional requirements and overall government strategic priorities
Parliament approves government budget estimates	30th June each year	National Assembly	Sets stage for development of appropriation bill to allow government to draw funds from the consolidated fund to implement the budget.

*Source PFM Act 2012*

### 6.1.2. Overall county government planning and budgeting structures and processes

Each county government should establish a County Treasury, which facilitates and oversees planning and budgeting, and overall management of public finances at the county level. The County Treasuries should establish a consolidated County Revenue Fund held in a Central Bank account, into which all revenue received from national government or raised locally should be held. Any withdrawals or payments require approval from the office of the Comptroller of Budgets at the National Treasury who is charged with the responsibility of ensuring that county governments adhere to government wide financial regulations. Key county planning and budgeting events relevant to the CDoH planning process are presented in Table 3.



Table 3: Summary of the overall county budget process

Key event	Timeline	Responsible Person/Institution	Comments
Development of county level sector specific Strategic Plans	End of first September after the election	Chief Officer of respective County Department	CoDH develops its five year Strategic plan, aligned to the Kenya Health Sector Strategic Plan
Consolidation of sector strategic plan to develop the Consolidated County Integrated Development Plan (CIDP)	End of first September after the election	County Treasury	County government aligns its CIDP with its campaign manifesto and with the National government MTP and Kenya Vision 2030
County Budget Review and Outlook Paper submitted to county assembly for approval	30th September each year	County Treasury	Outlines county government's budgetary performance for previous financial year and presents projected revenue for coming financial year, providing indicative allocations to all sectors and departments in the county
Resource bidding and allocation by respective county departments	October – December each year	All Departmental Chief Officers	CDoH having undertaken its review of previous year's performance undertakes bidding/lobbying for an increase or maintenance of budgetary allocation
County fiscal strategy paper submitted to county assembly for approval	15th February each year	County Treasury	Outlines broad county fiscal strategic priority goals of which county departments should align their budgets to
Submission for review of county budget estimates to County Assembly budget committee	30th April each year	County Treasury	County assembly scrutinizes proposed allocations and expenditure to all entities. Invites public participation in this process
Approval of county budget	30th June every year	County Assembly	Sets stage for development of county appropriation bill to allow county government to draw funds from the consolidated county revenue fund to implement the budget

Source PFM Act 2012

Within counties, all departments are supposed to develop a strategic plan, which are consolidated to form the County Integrated Development Plan (CIDP), aligned to the national government MTP. The CIDP should incorporate grassroots public participation, and be implemented through Annual Work Plans (AWPs). Resource allocation to all county departments should occur through an annual resource bidding process, guided by the departmental AWP. The county departments then develop departmental budgets, which are consolidated to form the overall annual county budget.

The CEC member for finance should then present the consolidated county budget to the full CEC for approval before submitting it to the County Assembly by the end of April each year. The County Assembly should invite submissions and inputs from members of the public and

other stakeholders during its deliberations, with budget approval by end of June each year. Within twenty-one days of budget approval, the County Treasury is required by law to publish and publicize the budget for general public information.

As highlighted earlier (chapter 3), under the DFRD arrangement, planning and budgetary responsibility for recurrent expenditure had been decentralized to the then district level. This had been done by designating the districts as accounting units. To this effect, these entities could receive and spend funds for day to day operational recurrent expenses. These funds would be sent to these entities by way of Authority to Incur Expenditure (AIEs) delegated by the permanent secretary of respective ministries, who had the overall accounting responsibility in the ministry.

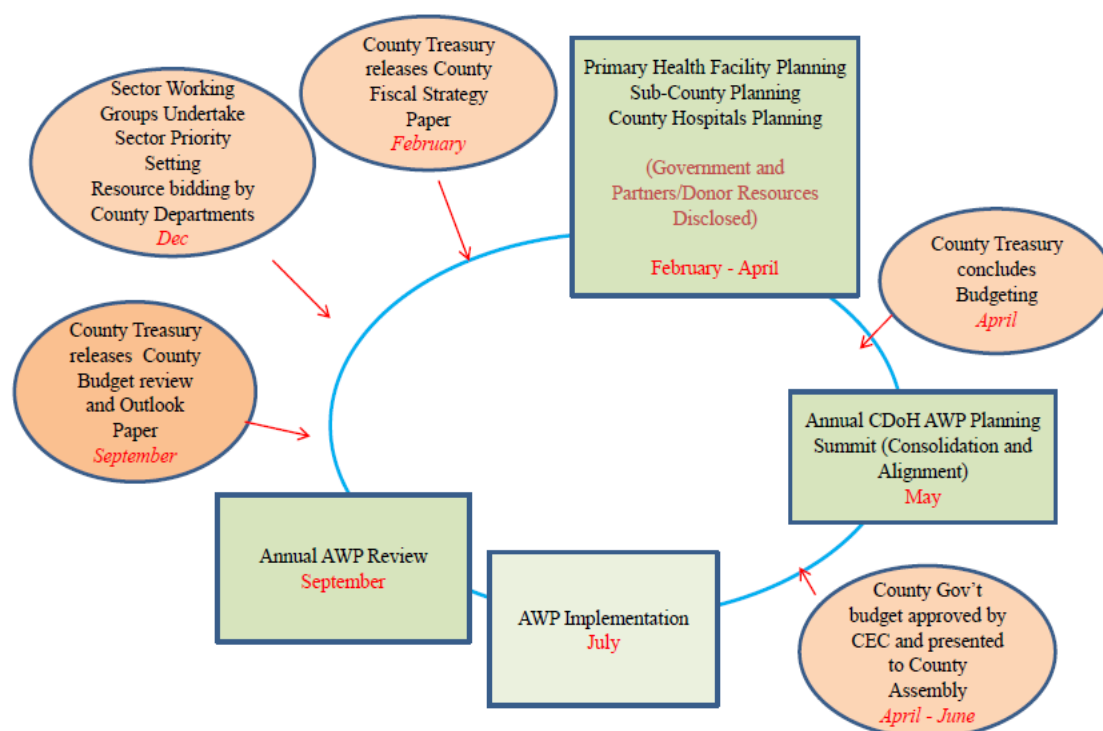
### **6.1.3. County level health sector planning and budgeting structures and processes**

Figure 7 below is an illustration of the CDoH planning and budgeting cycle. It illustrates the key events to be carried within the CDoH (green boxes) and how they link with the key events in the overall county budget process coordinated by county treasury, highlighted earlier (orange circles).

From the review of documents, the CDoH's AWP process should ideally begin in September with a performance review of the previous year's AWP and an elaboration of the subsequent year's priorities. It is these priorities that guide the CDoH resource bidding process once the county treasury publishes the County Budget Review and Outlook Paper (BROP) which gives a detailed outline of the projected county resource basket made of allocations from national government, and locally generated revenue; and outlines indicative allocations to county departments. Within the CDoH, the AWP planning and budgeting process is overseen by the CEC member for health, the County Chief Officer for Health, and the CHMT



Figure 7: Illustration of the CDoH AWP planning cycle



The County Treasury, CDoH and the County Assembly all have key roles in ensuring a smooth planning and budgeting process for the county health services. The county treasury has overall responsibility for the county government planning and budgeting process. It is thus required to provide overall guidance on how the planning and budgeting is to be undertaken.

Once they receive the circular providing the overall guidance, the CDoH is required to develop AWP tools and guidelines to facilitate all the planning units within the department to undertake their AWP. The AWP tools should adhere to the overall planning and budgeting guidelines released by treasury, and be aligned to the Kenya Health Policy (KHP) 2013-2030 and the Kenya Health Sector Strategic Plan (KHSSP) 2013 – 2017 which outline the country's broader health sector strategic agenda. All CDoHs countrywide are thus required to align their departmental priorities with the national health policy and strategic agenda.

Once all the planning units have undertaken the AWP planning, the CHMT should convene a meeting with all health stakeholders including implementing and funding partners, and the County Assembly Health Committee, to consolidate the work plans and outline the budget. The consolidated departmental plans and budget are then submitted to the County Treasury for incorporation into the draft county government budget for submission to the CEC and later to the County Assembly for approvals.

Under the previous government system, the national MoH, in-line with the DFRD policy had delegated the planning and budgetary responsibility for recurrent expenditure to the DHMTs at district level and HMTs at hospital level. Districts and hospitals were designated as accounting units which could receive and spend funds for operational recurrent expenses, with funds sent through Authority to Incur Expenditures (AIEs) delegated by the permanent secretary national MoH. Within the devolved system, the county government is expected to enact subsidiary local legislation to enable the Chief Officer Health to further delegate these functions to Sub-County Health Management Teams (SCHMTs) and HMTs.

#### **6.1.4. Additional funds for county health sectors**

In the early 1990s, through an Act of parliament, the MoH introduced a Facility Improvement Fund (FIF) to be financed through the levying of user fees at health facilities [100, 130]. Through this law, each health facility opened a bank account to deposit monies. On a quarterly basis, the HMTs would budget for the money and request for an AIE from the provincial office to use the money to pay for facility recurrent expenses. At dispensary and health centre level, this was implemented through the 10/20 policy which allowed for charging users a blanket fee of 20 and 10 Kenya shillings for health centre and dispensary services respectively [130].

The national MoH in partnership with the World Bank (WB) country office and the Danish Agency for International Development (DANIDA) in 2010, introduced a Health Sector Services Fund (HSSF) for financing recurrent expenditure for Primary Health Care (PHC) facilities in the country [100]. Under the HSSF structure, national monies were sent directly from national treasury to PHC facility bank accounts, eliminating DHMT and district treasury bureaucracy. Both WB and DANIDA contributed to this fund alongside the government. Health facilities were also required to have Facility Management Committees (FMCs) that comprise of some community representatives to play an oversight role in the utilisation of these funds. The FMCs were gazetted by the national minister for health, to acquire a legal status to carry out this mandate. With devolution, all the key stakeholders, i.e. national MoH, WB and DANIDA were keen to maintain this form of funding for PHC services as a conditional grant to counties. However, there was significant confusion and uncertainty over the future of HSSF at the roll out of devolution.

## **6.2. Health sector planning, budgeting and financial management experiences in Kilifi County**

### **6.2.1. Overview of the 2013/14 planning and budgeting process and outcomes in Kilifi County**

The Kilifi interim CHMT began a county health strategic plan development process in early April 2013. There was thus no AWP developed within the CDoH by the time the county budget process for 2013/14 was being concluded. The County Treasury went ahead to develop draft budgets for all departments including the CDoH without their active participation in order to avoid delaying the county budgeting process which has legally entrenched timelines.

There was little community or stakeholder involvement and participation in the health sector planning and budgeting process, but once the consolidated county budget was finalised, there was an attempt by the County Treasury to subject the budget to stakeholder reviews before it was finally presented to and debated by the County Assembly for approval. However, as highlighted earlier in the previous chapter, the County Assembly's capacity to adequately interrogate the county budget and make meaningful inputs and amendments was questionable.

Overall in this period, there were significant delays in accessing funds by the service units which significantly hampered service delivery. In the subsequent section, I present findings on the different effects the devolution process had on the planning and budgeting process in Kilifi County.

### **6.2.2. Delays and disputes in establishing CDoH structures**

A major influence on the planning and budgeting process in Kilifi was the delays and disputes in establishing county structures. The national MoH appointed and seconded interim County Health Coordinators to every county a few weeks before the general election in early 2013 with the mandate to set up interim county health coordination structures. Across the country, these county coordinators changed their titles to 'County Directors of Health' and established interim County Health Management Teams (CHMTs). In Kilifi, the interim CHMT designated the three former District Health Management Teams (DHMTs) within the County as interim Sub-County Health Management Teams (SCHMTs) and former Hospital Management Teams (HMTs) for the three referral hospitals as the interim HMTs. There were however no clear terms of reference or guidelines provided by national or county governments for the composition, roles and mandates of these structures.

This caused considerable challenges and confusion. For example, the membership of the interim CHMT kept expanding from an initial 12 members in early 2013, to over 20 members by end of 2013 with no clear roles and mandate. This happened because the then County Director of Health, who was a powerful provincial level manager of health previously, used her position to post some of her friends and allies to Kilifi from elsewhere in Coast region. This contributed to some CHMT members undertaking SCHMT roles (such as visiting peripheral health facilities to conduct supervision of frontline health workers) without reference to the host SCHMTs, leading to cases of both the SCHMTs and the CHMTs sending teams to the same facility for supervision on the same day.

The Chief Officer of Health like other departmental Chief Officers, was not appointed until April 2014. A Chief Officer for Finance in the County Treasury was appointed in May 2013 as an interim measure therefore had to assume accounting responsibilities for all departments. Although the CEC Health was appointed earlier in 2013, there was an observed tense working relationship between the newly appointed CEC for health, and the CHMT, which caused the stalling of the CDoH the Strategic Plan development process and the AWP development.

#### **6.2.3. Lack of clarity in CDOH versus national MoH roles**

At the time of the 2013/14 health sector planning and budgeting process, it was also not entirely clear what roles the CDoH would undertake *vis a vis* the national MoH in respect to health service provision as the proposed process of transfer of functions had not been agreed upon between national and county governments. These observations were also highlighted by some of the interview participants.

[...I think the experience was not a very exciting experience simply because when we came in immediately we were to discuss the budget. At this point the budget had already been aligned by treasury to what the different departments and within key budget lines and more or less the contributions we were to make were minimal...] KII C 001

[....I was lucky enough to participate in the budgeting process for the county, so and rumour had it that commodity, some people were saying that commodity procurement will still be done at the central government. It wasn't clear by the time we were doing this year's budget. It wasn't clear...] KII C 004

#### **6.2.4. Capacity of key actors tasked with planning and budgeting**

Beyond the structural delays and lack of clarity in roles, some interview respondents also felt that the individuals and structures tasked with the planning and budgeting responsibility at the

county level lacked the basic prerequisite capacity to comprehend and undertake this task, and this could have also contributed to the inability to undertake the planning and budgeting within the required timelines.

[...Capacity has been a challenge during the transition, we had the transition officers but were not very much adequate, so to me we didn't have that... we wished we could have been better facilitated in terms of capacity, the department needs to be beefed with more people, people in the budgeting section and in the planning section...] KII C 003

[...Then again the capacities of the CECs for example are moving now to developing strategic plans and developing sector plans, we have had a problem up to now. We do not have up to today sector plans. Sector Strategic plans. Even the AWP, they're doing work plans.....this is a primary school teacher who was picked from the classroom and made CEC, and she has no capacity to develop that and you're telling them today develop a strategic plan....] KII C 002

#### **6.2.5. Role and functioning of the comptroller of budgets**

A particular challenge for the 2013/14 fiscal year was that the comptroller of budgets rejected several county budgets, even after they had been approved by their respective County Assemblies. The affected counties were asked to revise their budgets to align them with the guidelines, in order for them to be allowed to draw money from the government consolidated fund:

[...when you prepare your budget and you submit to the controller of budget, and as works out and realize that your recurrent expenditure is over 70% then they tell you that your budget is not properly done, it will not be accepted and funds will not be released until when you revise that budget,...] KII C 003

Though established as a means of accountability by ensuring that counties adhere to government wide financial regulations, these regulations and functions of the comptroller of budgets were contested by some interviewees who felt that these budget regulatory requirements did not serve the interests of the counties. Some contested the interpretation of the laws regarding this oversight, while others felt that the regulations were actually preventing the counties from economic development.

[....say for example the office of the comptroller of budget, what they did last time was something which is un-procedural because it's not anchored in any law. If the county assembly has approved a budget, alright the controller of budget can only look at that

budget and if they feel that they are not happy with some of the things that have been contained, they can only hold the release of those funds but not to send it back to us to redo the budget you understand. Because even when we were amending the budget, I was asking myself, under which law are we doing this ....because the budget process is something which is anchored in legislation? On 30<sup>th</sup> of June, it should have been concluded, but now we are doing this things even in November and December....] KII C 007

[...Now today you say, you tell us we're decentralized but all accounts of the county government right now are being held by Central Bank. If this money had come into the county's treasury, the county treasury decides to put it in several banks, they would grow the economy there, but they're holding everything at the national level...] KII C 002

#### **6.2.6. Re-centralization of financial management roles at county level**

The lack of a Chief Officer for the CDoH in the better part of 2013 caused significant delays in accessing funds by the service units, thus hampering service delivery. As an interim measure all the financial requests for routine recurrent expenses by service delivery and coordination units had to be taken to the County Treasury for approval and financing. These included payment of utility bills, purchase of fuel for ambulances, stationery (for all health facilities and the SCHMTs) etc. This effectively caused a re-centralization to county level of what was previously decentralized financial management responsibilities at district (now sub-county), and hospital level.

[....right now as Kilifi the only challenge we have is the fact we don't have a chief officer .....,... then these people have to come all the way from Malindi, and Mariakani; the Malindi ones are ...they have to come here, you know...] KII C 002

The County Treasury owing to the workload of having to deal with the financial management for all the departments resolved to only deal with emergency requests. This compounded the delay in financial procedures, and led to frustrations by frontline managers particularly at the sub-county level.

[... We took the voucher since before Christmas, to the county treasury, around December yes they have not been able to pay the vouchers. So petrol also the same. We have to go and kneel down there before the supplier we cry if there is no phone and imagine if you don't have even recurrent money even to buy airtime, it means you have to go physically

if you miss him you have to borrow credit again so we are just running in debts...] KII SC 005

[...at the County treasury. .... At times we are told that the approving officer is not around so we will have to wait until that officer returns so that our requests can be approved. So we come back here many kilometres away to go there another day. ...like now we don't have oxygen in theatre, so we are referring all the patients because of oxygen...] KII SC 006

However even after the appointment of the Chief Officer Health in April 2014, the delegation and transfer of financial management responsibilities for recurrent activities at Sub-County and health facility level did not happen. Sub-county and health facility managers still had to travel long distances to the County headquarters to get approvals and financing for their recurrent expenses serviced by the Chief Officer.

#### **6.2.7. User fee lock-down in hospitals**

Given the challenges and delays in accessing county level funds for service delivery by the hospitals, the FIF user fees (which the hospitals continued to collect even after March 2013) were a potential alternative source of funds for these facilities. However, once the County Treasury was established in Kilifi, it directed that the FIF fell under what is collectively described as 'County Revenue' and thus the hospitals should close their respective FIF bank accounts and be banking the money in the County Consolidated Fund Account.

The CDoH was not happy with this directive, and for a whole year the hospitals continued to collect the money and banked it in the hospitals' accounts, but could not spend it because of lack of AIEs, even with the existing acute and emergency financial needs in these hospitals at the time.

[...What is happening in Kilifi since there is no consensus between those who are involved at the top there, the monies we have been denied to use them. Banking every day and banking everything the way the instructions were... six months down the line. We are talking about millions yes. And it is not clear still who is supposed to give the instructions to use the money...] KII SC 005.

[...We are banking 100% according to the policy and... Several millions like here I think it's more than 30 million is inside there, frozen; and yet we have the ambulance...that cannot be removed from the fundi (mechanic), imagine...] KII SC 005

Owing to the delays in accessing funds for addressing emergency needs from the county treasury and the stand-off over the use of the FIF funds, some of the hospital managers decided to spend the money they collected from user fees at source so as to address their emergency needs without seeking approvals.

[...now sometimes (XXX hospital) has been forced to spend money at source as I speak now they have spent almost 500,000 shillings at source. Yeah because how do you survive, we don't have water, we don't have electricity you have no supplies, patients don't have food and you have debt of around 2 million just for food alone, and such kind of things we are talking about....] KII SC 007

#### **6.2.8. Access to HSSF funds and abolition of user fees**

An additional source of funds to support service delivery particularly to primary health facilities was the HSSF (described in chapter 3). These were funds put together as a contribution by national government and two main donor agencies, DANIDA and the WB and would be sent into PHC facilities directly from central level treasury, to cater for recurrent expenses in these facilities. However, in the early days of implementation of devolution, there were contestations over the roles of national and county government in the management of these funds. First the CDoH wanted to be the one to undertake the selection and gazette of the FMCs who were key in the management of these funds at the facility level, arguing that managing PHC facilities fell within their mandate.

Another contention, and which both major HSSF donors i.e. WB and DANIDA were drawn into, was regarding the channel and flow of funds. The national MoH wanted the flow of HSSF funds to remain as prior to devolution, i.e. move directly from national treasury to facility bank accounts. This position was also supported by the WB. The county governments however wanted the funds to flow through the County Treasury, a position which was also supported by DANIDA. These contestations were also recounted by some of the participants in the interviews.

[...am hearing that there is still a tug of war between the county and national government. The county wants to gazette, to do the gazette because they claim this is a county function. The national government also wants to do that...] KII SC 02

These contestations led to a significant delay in the release of funds. Ultimately when consensus was agreed for counties to gazette the FMCs but the funds to go straight to the facility accounts, DANIDA was still not happy with the decisions, and thus they withheld their



contribution into the HSSF kitty, leading to significant reduction of the total amount to health facilities.

In June 2013, the president issued a directive that all user fees at PHC facilities be abolished and all maternity services be provided for free at all public health facilities. Under this directive, the national government through the national MoH was going to compensate health facilities for the revenue that would be lost through this directive. However, the roll out of the health facility compensation was significantly delayed because of contestations between national and county government over the mechanism to be used to channel funds for this programme. At the same time clients began seeking these free services as per the directive, thus causing further straining and challenges for service delivery at facility level; and because of the public popularity and political nature of the directive, the county governments did not want to contradict this directive publicly for fear of political repercussions.

Owing to the pressure that this directive put on the health facilities, which were already suffering from funding constraints due to lack of structures at county level, sub-county health managers advised the PHC facility managers to meet with their respective FMCs and agree to re-introduce the user fees till a time when they get reimbursement.

[...this declaration has impacted on in terms of service delivery at the dispensary. It's been very-very ... it's been very difficult....] KII C 001

[...So what we've decided to do is for the dispensary, the heads there to call a baraza (community meeting) with the chiefs around and to communicate with the communities to allow them to pay at least 10 shillings for the service...] KII SC 002

### **6.3. Summary**

In summary county governments mainly get their resources from national government as part of the equitable share, equalization fund for certain counties, or conditional grants; as well as – to a lesser extent - from revenue generated locally within the county. During the county level budgeting process, the CDoH gets resources allocated through a resource bidding process which also includes other county departments. Once it has its resource envelope, the CDoH is required to engage all its planning units in a bottom-up process to develop its AWP. In the 2013/14 financial year, the CDoH in Kilifi County did not adequately participate in the planning and budgeting process at county level. This was largely due to the fast tracked transfer of functions described in chapter 5. During the time for the key planning and

budgeting activities in the county, the CDoH structure was not fully established with key officers not yet appointed. There was also lack of clarity and confusion by the interim team over what functions the CDoH should plan for in relation to the national MoH. Subsequently, even after the appointment of key officers and establishment of the CDoH structures, there was significant lack of capacity by the team over their planning and budgeting roles.

The delay in setting up CDoH structures, lack of appropriate planning, budgeting and general financial management skills, and overall political contestations led to perverse re-centralization of financial management function at the county level, user fees lock-down in hospitals and delays in the release of critical HSSF funds to PHC facilities. All these challenges collectively led to difficulties in access to funds by service delivery units, which significantly disrupted health service delivery at the county level.

## **Chapter 7: Health Workforce Management under Devolution**

### **7.0. Introduction**

In this chapter, I present findings on the structures, processes and early implementation experiences of devolution on health workforce management. I begin by outlining the proposed national and county level health workforce management structures, and their roles and responsibilities under the devolved government system. I then describe how the transfer process of the health workforce management function was undertaken, and the early outcomes and effects of this transfer. I drew data for this chapter largely from document reviews, key informant interviews and the general observations at the time; and the reflective practice sessions with other learning site research team members.

### **7.1. Proposed structure and process for public servants' management**

#### **7.1.1. National and county level structures for public servants' management**

Within the old constitution, a Public Services Commission (PSC) served as the overall employer of all government workers, including health workers in the country. The role and function of this PSC was to provide overall guidelines and oversight for strategic human resource development and management in the public sector, while the routine operational human resource management functions including recruitment, appraisal, promotions, discipline, in-service training and payment of salaries were delegated to the respective government ministries. The national MoH therefore undertook the role of all operational routine health workforce management functions for all health care workers in the country.

Under the devolved government system, the 2010 constitution left the PSC with the main mandate of providing employment for national government employees, and an oversight role for the entire public service both at national and county level. At the county level, the constitution provided for the establishment of County Public Service Boards (CPSBs) that would serve as the overall employer of all public servants at the county level. The CPSBs were to be established as independent county level institutions, but accountable to both the County Executive and the County Assembly. In undertaking their human resource management function, the CPSBs are to do so in consultation and coordination with the respective county departments.

#### **7.1.2. Proposed transfer process of the public servants' management function**

Legislation stipulated that all public servants performing devolved functions at the time of the general elections on March 2013 would be seconded to the county governments where they are

working, to be formerly deployed or transferred to those county governments once the county human resource management structures are established. In the health sector, national MoH in liaison with the Transitional Authority (TA) was to undertake a human resource capacity assessment for the counties [34, 125]. The TA was to further work to build capacity for all CPSBs to enable them undertake the assigned public service management function, and then work with respective ministries to transfer all staff working in the counties to from the national government to the respective county government under the CPSBs.

[...Any public officer appointed by the Public Service commission in exercise of its constitutional powers and functions before the coming to effect of this Act and is serving in a county on the date of the constitution of that county government shall be deemed to be in the service of the county government on secondment from national government with their terms of service as at that date ...] County Government Act 2012 Art 138

## **7.2. Early implementation experiences and outcomes of health workers' management under devolution**

### **7.2.1. Lack of clarity over health workforce management roles and functions at county level**

At the national level, the PSC had clearly delegated the function of routine operational public service management to respective ministries. However, this did not happen at the county level [36]. This led to some confusion on the exact roles and responsibilities of health workforce management between the different government structures, and especially between the CPSB and CDoH.

[...But again, those roles have not been shared with us in terms of who is to do what and as far as I can tell, I need; for us at least for the department of health we need to be made aware ... to fully comprehend what kind of health workforce management roles do we have ...] KII C 001

[...Things were not also very clear with this human resource management issue, it's not clear who is to undertake what role....] KII SC 005

There was also lack of clarity over what structures and institutions between national and county governments would be responsible for specific welfare aspects of health workers including in-service training and career progression, and how inter-county transfers for health workers would be managed. Confusion over transfers was particularly expressed among Sub-County level interviewees:

[...Now the movement is still not very clear to us with, I mean now outside the county. So today we had a meeting with the director but we didn't discuss it, we just talked about the persons who want to be moved within the county but the question of movement outside the county remained un-answered....] KII SC 002

[...It's a hazy topic, we don't know what is going to happen. Now if somebody would now start thinking if am working in Tana River for example, now does it mean that all my life I will stick there.....] KII SC 007

### **7.2.2. Rushed transfer of health workforce management functions**

As with other devolved functions, the health workforce management function was also hurriedly transferred to counties in July 2013, following the presidential directive at the time. In Kilifi as elsewhere, this happened at a time when the basic systems required for managing the human resources had not been set-up. In the CDoH for example the payroll management system had not been set up and thus the county like most others could not process and pay health worker salaries at that point. There was a strong feeling by some of the health sector participants in the interviews that the county governments were prematurely pushing to take up the health workforce management role for political reasons, before working to set up the structures to take up that role at the county.

[...They (governors) would have taken some time for it (health workforce management systems) to be established well. So that is the challenge that we are seeing and it's really affecting health workers and most of them are not really comfortable with what is happening...] KII SC 007

[...You know I think the challenge with the ... most county governments is having time to learn how the system was and how that can be adapted in this needy situation. Because the ... all the ministries at least had their own system of operating, but now that we have devolved, how do we customize that? Now that needs sober minds, all the players to ensure by the end of the day we are focusing on service delivery; that is critical.....] KII C 006

### **7.2.3. Dialogue and consensus building over health workforce management**

Given the rushed transfer and the potential challenges it brought on health workforce management in counties at the time, several health sector stakeholders at national level began to discuss this health worker management challenge. To try and avert a crisis of counties failing to pay salaries for health workers countrywide, the Health Sector Intergovernmental Relations

Forum, that brings together national MoH with all the 47 CDoHs, was convened to develop an interim solution to address some of these pending crises.

As a result of this dialogue, consensus was arrived at that the national MoH would continue processing and paying salaries for all health workers on behalf of the counties, then invoice the county governments for reimbursements for an interim period of July to December 2013. It was expected that counties would take that six months' interim period to set up their systems, leading to them taking up the role of health worker salary payments by January 2014.

[....And I think through you know negotiations with county governments, I think they accepted that national government would continue paying salaries of county workers in the interim up to December 2013 as they prepare themselves...] KII N 001

After this agreement between national MoH and CDoH, all counties including Kilifi, decided to undertake a head-count of all health workers within their areas to verify if they were being invoiced for the right numbers. During this exercise, the health workers were required to physically present themselves for the head-count, and provide their personal details including details about their tribe, home-county and constituency of origin. This head-count exercise generated significant debates and arguments within the health sector at the time. First, the health workers were uncomfortable with the requirement to disclose their tribe and 'home county' during the exercise, for fear of discrimination and victimization. Secondly, most counties noted that the actual names and numbers of staff that they were being invoiced by national MoH for did not exist within their counties. Counties thus claimed that these were 'ghost workers' and threatened to refuse to re-pay salaries paid to these people by the national MoH under the interim agreement.

It took the convening of another health sector intergovernmental relations forum meeting to address these concerns from the counties. At this meeting, the health sector FACT explained to the counties that staff movement and transfers within the sector had traditionally been conducted manually at district, provincial and national level. It thus took sometimes up to two years before a staff transferred from one station to another had their transfer reflected in the payroll management systems. This meant that several months after being transferred, a health worker will continue to have their pay point reflected as the old station, and would have their salaries budgeted for that station. This explanation generally appeared to be accepted by the counties when they were made to understand that the salaries budgeted and allocated for health workers in the counties in the first year, were for those workers with pay-points within those counties and not necessarily those working within the county at that time. However there was

also consensus that this health workforce records anomaly needed to be corrected urgently and county records to only reflect the health workers working in those counties.

[...I don't know whether they are called ghost workers when they are found for instance all the provincial hospitals that were actually places for intern doctors training you know your salary started there and if you were at the Coast General you were posted outside, your payroll points is still Coast General and then that budget is yet counted at the Mombasa county but the doctor is no longer there, so this are some of the issues that are actually being dealt with....] KII N 008

[...It needs to be corrected, if it's been done and there's consensus about the headcount in the whole country, there's need for the governors' council of all the counties to sit with central ministry and correct the anomaly of the headcount.....] KII C 006

#### **7.2.4. Public participation and accountability in recruitment of senior public servants**

As was required by law, for the first time in the country's history, there was an opportunity for public participation in the appointment of senior public servants including Cabinet Secretaries and Principal Secretaries at National level, and County Executive Committee (CEC) members and Chief Officers at County level. The president (at the national level) and governors (at county level) nominated individuals for appointment into these positions. The nominated individuals' names were then submitted to respective assembly committees for a public vetting exercise. Members of the public were invited to present their views in the form of memoranda to the vetting committee, in support of or in contest of the appointment of the nominees. The nominees were then appointed after clearance by the vetting committees. However from observation at both national and county level, this was seen by many as a public relations exercise as many people felt that both the members of the National Assembly at the national level, and the members of the County Assemblies at county level did not have the required skills and capacity to undertake meaningful assessment and vetting for the public officers they were supposed to vet. Secondly there were strong perceptions that both the national and county assemblies were regularly compromised by their respective executive arms of government, through allowances and other inducements so as to 'rubber stamp' executive decisions and choices.

[....You see. So public participation is very weak, very very weak; because when you bring a bill, you bring them (Members of the County Assembly) here to take them through ... you actually invite the committee to take them through the Bill. Pay them a

sitting allowance; When they get it there at the assembly, they will not raise a finger on it....] KII C 002

An example of perceived compromises in the process is as follows. During the national vetting of cabinet secretaries, the National Assembly vetting committee rejected the nomination of one of the proposed cabinet secretaries on the grounds of her qualification for the proposed job.

[....The Committee rejects the nomination of Mrs. Phyllis Jepkosgei Kippingor-Kandie as the Cabinet Secretary for East African Affairs, Commerce & Tourism and recommends that the appointing authority submits the name of another person for consideration in accordance with the provisions Section 7(10) of the Public Appointments (Parliamentary Approval) Act 2011...] *National Assembly Committee on Appointments of Public Officers, Report on Vetting of Cabinet Secretaries, 14<sup>th</sup> May 2013*

However once the committee submitted this recommendation to parliament, the executive called for a meeting of the members of parliament from the ruling party where it's alleged that they were bribed and coerced to reject the recommendations of the committee when they get to the floor of parliament. Subsequently this report was rejected and the nominee cleared by parliament. The president proceeded to appoint her into office. Both the cabinet secretary and principal secretary at National MoH, and the CEC and Chief Officer health at the CDoH in Kilifi, were recruited in this manner where there was some initial rejection of some of the nominees, but after allegations of bribery and political coercion, these individuals were approved for appointment.

#### **7.2.5. Political interference and discrimination in health workforce management**

Political interference and discrimination in the management of health workforce begun to be reported in some counties across the country immediately the devolution process begun. One national level interviewee highlighted an example where in mid-2013, the national MoH deployed and posted out to counties a group of freshly qualified medical doctors who had completed a one-year statutory government internship training as required by law. It was however reported that some of the counties rejected the doctors sent to them because they had come from different tribes or counties from the ones they had had been posted to.

[...It's tricky, because actually that has happened in the health sector few weeks ago, Dr. XXX (Senior Officer in national MoH ) posted out some doctors who had either finished training or internship and some counties rejected them claiming they didn't come from those counties....] KII SC 007



Another incidence is related to the national MoH 'Economic Stimulus Programme' (ESP). Two years prior to devolution, the national MoH partnered with the United States Agency for International Development (USAID) Capacity Project to recruit health care workers to address the nationwide staff shortages that existed. Under this agreement, the GoK through MoH was to increase allocation for recruitment of health care workers and the Capacity Project would match that allocation with an equivalent amount. In the implementation of this arrangement, the GoK carried out a decentralized recruitment process through setting a recruitment quota for every constituency which ensured that the staff recruited were largely from the locality (constituency) they were recruited from. The recruitment for the staff supported by the Capacity Project was however done centrally by national MoH, with the staff then distributed equitably across the whole country. This meant that Capacity Project staff were not necessarily deployed in their home locality.

From the general observations over the course of my research, several counties agreed to absorb only those health workers who had been recruited locally through the GoK funding, and rejected those recruited and deployed through the Capacity Project as they were considered 'outsiders'. This led to the USAID Capacity Project in February 2014 giving all the staff employed through the project who had been rejected in the counties where they were working a notice of termination of contract for end of March 2014. In some counties as highlighted in Figure 8 below, some of the nurses affected went to the industrial court to compel their respective county governments to absorb them.

There were 47 health workers in Kilifi County under this category, who were initially affected leading to significant disruption of services including total closure of two health facilities which were being pre-dominantly served by this category of staff at the time. However, when the new Chief Officer Health was appointed, he managed to negotiate with the CPSB to have them reinstated.

Figure 8: Newspaper article highlighting the plight of the affected ESP nurses in one county

THURSDAY, OCTOBER 16, 2014

## Industrial Court reinstates 177 Murang'a health workers



Health workers from Murang'a when they appeared at the Industrial Court in Nyeri on October 15, 2014 for hearing of their case. Judge Byram Ongaya directed that the 177 workers be reinstated pending the hearing and determination of their petition. PHOTO | JOSEPH KANYI | NATION MEDIA GROUP

By FAITH NYAMAI

The Industrial Court in Nyeri Wednesday reinstated 177 health workers from Murang'a who had been sacked by the county government for refusing to sign a return-to-work agreement.

Judge Byram Ongaya directed that the workers should continue working in their respective health centres under conditions provided in previous contracts and to continue receiving their salaries pending the hearing and determination of their petition. The county wanted them to continue working on contract.

"I therefore direct that the workers continue receiving all the salaries and remunerations," he ruled.

### PERMANENT EMPLOYMENT

In their petition, the workers want the Murang'a County government to employ on permanent basis all health workers who had been hired on contract basis through the Economic Stimulus Programme.

Political interference with health workers was also reported at facility levels. During one reflective practice session with sub-county managers in Kilifi, it was reported that one dispensary within the Kilifi sub-county had been closed because community members led by their Area Member of County Assembly (MCA) had demanded to have the only nurse at the dispensary transferred because she did not belong to the locality. Sub-county level interviewees reported that this growing level of political interference and victimization raised significant concerns among health workers.

[....the concern of health workers you know it's like we are leaving a lot of decisions to remain by the politicians so what happens to technical skills. What happens to for example you having becoming a medical officer, you becoming a physician, what

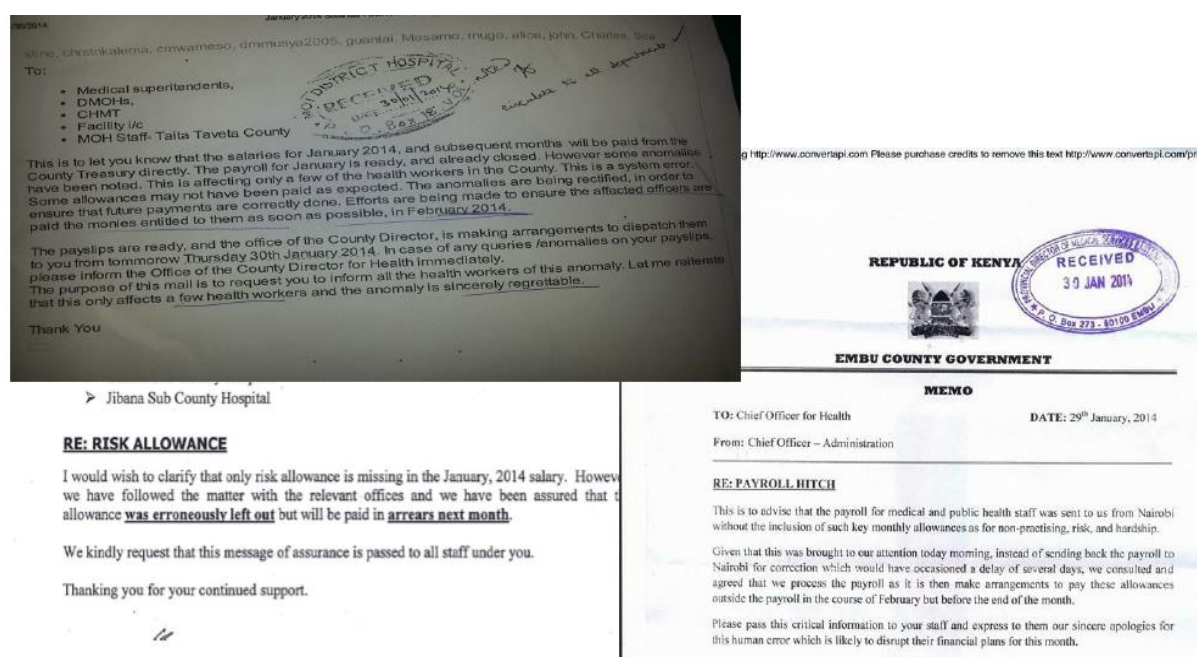
happens now? You know it's now like decision making processes and almost everything that you are going to do is going to be dictated by the politics and that might not be such a very good [situation] ...KII SC 007

## 7.2.6. Disruptions, delays, and discrepancies in health workers' salaries

From the general observation, county governments went ahead to prepare their payroll management systems in readiness for undertaking the role of paying salaries for health care workers by January 2014. However, when they eventually took up this role the initial months were characterized by several challenges including general delays in salary payments, payroll discrepancies and missing allowances; and some staff missing from the payroll altogether. When the salaries were eventually paid, it was noted that a number of key allowances had not been included for most staff. Figure 9 below is an illustration of some of the existing health workforce payroll challenges at the time across counties.

In Kilifi County, there was a general delay for payments of January and February 2014 salaries by over 2 weeks in both months. And in both instances, there were major discrepancies in the payroll when the salaries were eventually paid

Figure 9: Illustration of the wide-spread health workers' payroll challenges at the time



## 7.2.7. Fears, anxiety, low morale and industrial actions by health workers

The multiple challenges and uncertainties over the health workforce management highlighted above led to significant fear and anxiety among many health care workers at the time. The main concerns health care workers had included the uncertainty about career progression,

uncertainty about inter-county transfers, the increasing political interference over health worker management, and the continued disruptions in salary payments. These concerns were also raised by respondents in the interviews.

[...This grey areas are actually raising up apprehension, apprehension and what do we call it; health workers are feeling sort of intimidated or something by the political process...] KII SC 007

These multiple uncertainties over health care worker management issues not only resulted in fear and anxiety among health care workers at the time, but also led to observed significant levels of demoralization of health care workers.

[...So that is the challenge that we are seeing and it's really getting health workers and most of them are not really comfortable , ..... the morale is not that good, it's not that good...] KII SC 007

[...But right now to tell you about the human resource in general within the rural facility, within the hospital, people are fatigued because of the amount of work, and the morale is very low because of these problems....] KII SC 004

The fear for political interference and victimization, coupled with the uncertainty over inter-county transfers generally led to many health workers wanting to be transferred back to their home-county of origin. These observations were also raised by respondents in the interviews.

[...up to August last year, there had been so many transfers. People were requesting to move away to go back to their home counties people were in state of panic not sure about how the host counties would treat them so they wanted to go back to their homes....]  
KII C 008

Owing to these challenges at the time, the national media continued to report on cases of mass resignations of health workers countrywide. In late 2013 the three major health worker unions in the country called for a nation-wide strike citing these challenges and pressing for re-centralization of the health service delivery function back to national government. During this strike which lasted for several weeks, health care workers countrywide resorted to several protest strategies including street demonstrations and social media protests. This happened at the time when the country was undertaking the 50<sup>th</sup> anniversary of the country's independence. The anniversary celebrations lasted for several days in December 2013, and had more than ten visiting heads of state from other African country's attending.

To take advantage of the anniversary celebration, health care worker social media protest adopted a twitter hash-tag [#sick@50](#) to pile pressure on the national government to come to their rescue; however, during the celebration, both the president and his deputy stayed clear of the health sector crisis in their addresses to the nation; highlighting the varied and potentially politically sensitive nature of this debate at the time. Some views and positions about the health workers' strike were also raised by the respondents in the interviews;

[...I think if we look at these, especially events leading to what we have, the current crisis situation we have the human resource in the ministry is kind of, things were done in a bit hurried, in a hurried manner before setting up the proper structures at the counties, because you see at one time we had the governors going to the president's, ah, to the State House and that same day you get, a Gazette Notice saying that you have to devolve these functions fully. So you see there was some hurriedness in doing that....] KII C 004

As the health workers' strike continued, and the political debate surrounding health devolution continued, the national media continued to publish horrifying stories and testimonies about the devastating effects of the countrywide health workers strike. Media reports at the time estimated that by end of December 2013, over 100 Kenyans had lost their lives in public health facilities owing to the strike.

Figure 10 below is an illustration of the health workers strike, its effects; and raging debate as covered by the media at the time.

In response to this strike action, the Council of Governors (CoG) met in Nairobi and took a joint political decision to lay off all striking health workers within their counties. Several counties went ahead to actually sack all the striking health workers; and re-advertised their positions. Kilifi County did put up an advertisement in the press, in late December 2013 for all health worker positions in the county. This action by county governments, together with realization that they (health care workers) could not negotiate for a return to work arrangement centrally, but instead had to do so with respective county governments, softened the position and stand of the health worker unions prompting them to call off the strike in early 2014. Many people at the time, queried why well-informed health workers would call for a strike over a course they knew they couldn't win, considering how popular devolution was at the time



Figure 10: Media coverage of the 2013 health care workers strike, its effects and the raging public debate then



## 7.2.8. Contestations, power battles and push for recentralization of health services.

Following the strike and the health care workers' push for the re-centralization of the health care function to national government; the debate attracted the political class pitting the CoG against members of National Assembly. The National Assembly Departmental Health Committee in mid-2014 did a rapid assessment on the process and effects of devolution in the health sector and published a report on its findings largely recommending that the health sector devolution be reversed back to national government.

[...The Committee observed that issues relating to health care workers remain contentious post devolution particularly on hiring, training and capacity building of

health workers. The Committee also took note of the hostilities faced by Ministry of Health personnel seconded to counties...] Parliamentary Health Committee Report on Devolution in the Health Sector 2014 – pg. 7

[...The Committee therefore recommends the reversal of devolved health functions back to the National government and further restarting the process in an organized and consultative manner as taking into consideration the three-year window as provided by the Constitution...] Parliamentary Health Committee Report on Devolution in the Health Sector 2014 – pg. 8

This report was largely perceived by many critics as having been non-analytical and non-objective in its recommendations, but rather was seen as an attempt by the National Assembly and National government generally to wage war against the county governments by portraying them as having failed in their functions.

This debate of re-centralizing the health service delivery functions in the country generated wide public debates with supporters and critics alike. These varied views were also raised by the respondents in the interviews.

[...there is misunderstanding, when doctors say that they will not deliver services they don't want their salary to be paid by counties and that's why devolution must not happen, to me I real would want them to be held accountable to tell us a bit, why they are saying so...] KII N 005

[.... So that is another issue that health workers are raising right now having people who are not trained from the medical side are the ones who are making decisions especially the politicians, the health workers don't want that.. ...] KII SC 007

[...the doctors were not prepared psychologically; they only waited for rumours atitunakuwa (we hear we shall be) devolved until that happened ....So national government there failed in the sense of buildings capacity of people, preparing them adequately for devolution especially sensitive sectors like health...] KII C 002

The debate was also extensively covered by the national media at the time, and at some point the National Assembly committee started developing a bill to enact a law that would force the national government to take up the health service delivery function. Figure 11 is an illustration of the media coverage of this debate at the time.

[illegible]

### 7.3. Summary

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The transfer of the HRH management functions, similar to other county functions, was hurriedly implemented in 2013 before proper structures for taking up these functions had been set up at county level. This led to fears, anxiety and low morale among health care workers, resulting in mass resignations and strikes.

The early days of devolution were characterised by political interference in HRH management and victimisation of health workers, leading to some health care workers wanting to be transferred to their home counties. Given the emerging crisis in health care worker management, and particularly inability by counties to pay salaries, an interim arrangement was agreed following dialogue between counties and national MoH, for national MoH to continue paying staff salaries for an initial period of six months. In early 2014, county governments took over the payments of health worker salaries – a process that was characterised by several challenges including missing names in the payroll, missing allowances and salary discrepancies.

## **Chapter 8: Essential Medicines and Medical Supplies Management under Devolution**

### **8.0. Introduction**

In this chapter, I present findings of how the Essential Medicines and Medical Supplies (EMMS) management was supposed to be carried out within the health sector under devolution, and how it was affected by the early days of devolution. I begin by describing the composition, roles and capacity of EMMS management structures, and the process of devolution and transfer of the EMMS management role to counties. I conclude the chapter by highlighting early outcomes of the devolution of EMMS management.

### **8.1. Organization and process of EMMS management under devolution**

#### **8.1.1. Composition, role and position of the Kenya Medical Supplies Agency**

Prior to the roll-out of the devolved government system in the country the Kenya Medical Supplies Agency (KEMSA) - established through an act of parliament as a state corporation under the national MoH - had the statutory mandate for procurement, warehousing and distribution of all medicines and medical supplies to all government health facilities within the country. It was constituted as a national government entity governed by a board of management and a Chief Executive Officer, both appointed by the national Minister for Health. In partnership with KEMSA, the national MoH adopted a ‘pull’ system for EMMS management and supply for public health facilities. Under this system the national MoH would allocate the quota of its annual budget meant for EMMS to KEMSA. This allocation would then be subdivided and allocated to all gazetted government health facilities in the country based on a resource allocation criteria developed by the national MoH. The resource allocation criteria factored in several issues including facility type, facility work-load and the district where the facility was located. Based on the facility allocation for EMMS, KEMSA would then establish an account for each facility known as ‘drawing rights’ to run every financial year. Health facilities would then make orders (‘pull’) from their drawing rights at KEMSA on a quarterly basis and KEMSA would service the facility orders while crediting the facility allocation.

However, this pre-devolution pull system faced significant challenges, and health facilities often reported prolonged delays in servicing their quarterly orders by KEMSA, and very low refill rates, leading to long periods without essential supplies.

In its analysis of the EMMS supply situation in the country at the time, the MoH FACT team in their policy report acknowledged that there were challenges with KEMSA, but attributed

these challenges largely to an inadequate EMMS allocation made to KEMSA by the MoH. The report also stated that data used to undertake the facility EMMS quota allocations were often inaccurate.

[...Currently routine Essential Medicines and Medical Supplies are procured with inadequate financing (<50% of needs) on the basis of annual quantification using incomplete or inaccurate data, on behalf of the Ministries of Health by KEMSA...] MoH FACT Policy page 29

### **8.1.2. Proposed arrangements and stakeholder expectations for EMMS management structures and processes under devolution**

In early 2013, a few weeks before the general election, the KEMSA board of management working with parliament lobbied and managed to obtain an amendment to the KEMSA Act to expand the mandate of KEMSA to conduct business with county governments once they were established. This is because, under the proposed devolution structure and the functions outlined in schedule four of the constitution (Annex 2) EMMS procurement was categorised under health service delivery, which was part of the broader mandate of county governments. County governments would thus be the ones to allocate resources for and procure drugs and other medical supplies for government health facilities within their areas.

Given many years of perceived inefficiency in KEMSA, county health managers welcomed the proposals of devolution for allocating drugs and commodity supplies resources to counties, reporting that this would give counties greater bargaining power to demand for more efficient supply service from KEMSA. They also felt that if KEMSA is unable to meet their needs, they would be in control and in a position to decide to source out for alternative suppliers.

[....I would say devolution is a good thing because we've consistently been complaining about KEMSA and now that we have this is actual money. It's no longer drawing a virtual imaginary figure. This is actual money, then we expect better supply, we expect better supplies for our facilities in terms of quantities and also in terms of variety of the medicines... most of the items from KEMSA we will procure from them, then what is not available at KEMSA especially for the hospitals, we've asked them to prepare a separate list of items not on the KEMSA commodity list and for that we will float a quotation.....] KII C 004

[...Yes exactly, it will give us better Fill rates. It is a better thing...] KII SC 004

Several institutions have a role in the EMMS management function under devolution [33-35]. The process begins from the health facility level, where the facility in-charge undertakes

EMMS stock management, undertakes quantifications and submits projected facility requirements to the county pharmacist. At the county level, the county pharmacist within the County Health Management Team (CHMT), is charged with the responsibility of providing technical assistance to facility managers on quantifications. The county pharmacist then analyses and consolidates all the orders from health facilities, prepares purchase orders and submits them to the county treasury. The procurement department at the county treasury is charged with the responsibility for the tendering process for the required commodities. This was also explained by county level interviewees:

[....So the technical components will be done by the county pharmacist in terms of quantification ... and they have just finished ... they've refined what the needs for all health facilities at all levels are, what kinds of drugs that they'll need. ] KII C 001

[...So we'll take the orders when they come from the facilities, they have to do, we have to do the LPO (Local Purchase Order) and then take to the County Procurement Department at county treasury. The procurement office for them to float tenders.....] KII C 004

Community involvement and participation in EMMS management is supposed to occur at several levels. First during the priority setting, planning and budgeting process health facility managers are supposed to sit and consult with the health Facility Management Committees (FMCs) made up of community representatives. The facility in-charge is further supposed to consult with the FMCs during the commodity quantification and ordering process. Finally once the orders have been supplied, the FMCs should be involved in ascertaining that the right orders have been delivered before payments are made to the suppliers.

[.....community involvement especially with the new dispensation, it is very important. We need to sensitize our communities even when the drugs, the commodities are supplied to the facilities, they should be told that we have received this consignment and in this quantities ..... delivery notes, they have to be signed by 3 people. The facility in-charge the facility committee chairperson and another person from the facility management committee ...] KII C 004

During the transition phase, the national MoH had proposed that the funding and supply management role for EMMS be retained at national level for a period of one year as counties prepare their structures and capacity to take up this function. This proposal was highlighted in the MoH FACT Policy.

[....due to existing programme and financing commitments together with economies of scale and quality assurance considerations, the status quo is maintained in terms of funding mechanisms and supply cycle management responsibilities but with continuing improvements to systems, procedures and processes and fully consultative preparation of all required guidelines for effective county commodity supply management and utilization....] MoH FACT Policy page 29

## **8.2. Early implementation experiences and outcomes of devolution on EMMS management**

### **8.2.1. Rushed transfer, confusion and county level capacity for EMMS management**

As with the other devolved functions, the EMMS management function stood devolved with the presidential directive of June 2013. This happened when there was still lack of clarity and confusion over who would be in-charge over the EMMS management roles, and whether EMMS funds had been allocated to county or national government:

[....I was lucky enough to participate in the budgeting process for the county, but and rumour had it that commodity supply,...some people were saying that commodity procurement will still be done at the central government. It wasn't clear by the time we were doing this year's budget. It wasn't clear. So lucky enough for us we had budgeted for commodities both pharmaceuticals and non- pharmaceuticals....] KII C 004

There were also significant challenges for the health facility managers in undertaking the required quantification of needs for drugs and other commodities for their facilities. To compound this capacity gap there was only one county pharmacist at the CHMT level who had been trained to provide the technical support to all the over one hundred health facilities with the commodities quantification process.

The EMMS budgetary allocation was sent to counties following the presidential directive to transfer all county level functions in June 2013. However, at the time, there was a strong push by national MoH to try and compel counties to procure all their drugs and other commodities from KEMSA. This push was strongly resisted by the county governments, and the Commission for Constitutional Implementation (CIC) declared the push by the national MoH at the time as unconstitutional. The county governments argued that if KEMSA wanted them to procure commodities from it, then the composition of KEMSA should be reconstituted to include county representation in the board of management.

[..... they (national MoH) wanted initially through legislation, to require counties to make KEMSA be the first point of call for buying commodities, but that was very unpopular and you know CIC also said that was unconstitutional because procurement since you know it is service delivery function so it's a role of counties, ....] KII N 001

[..... KEMSA sets itself up as the national government agency but the national government agency takes resources that belong to counties. So we advised as CIC; as currently constituted KEMSA is unconstitutional. So KEMSA either needs to be changed into an inter-governmental parastatal or it can be used as national then it can only procure for Kenyatta and Moi (national Hospitals) but if it should procure for the counties there must be an intergovernmental agreement whereas the counties agree to delegate their right to procure to the national government agency ....] KII N 005

As this debate went on, there was a reported widespread drug shortage in public health facilities across the country. In its routine field visits to assess the progress and county preparedness to undertake the devolved health functions, the National Assembly Health Committee at the time noted and raised concerns over the problem of drug shortages in counties across the country. Noteworthy at the time the committee visited Kilifi County, the Interim County Director for Health in Kilifi was also cited to have acknowledged that Kilifi County was facing significant drug shortages, and she requested the national government to intervene on this problem. This illustrated lack of clarity even amongst senior level county managers over who between national and county government had responsibility for EMMS management. Figure 12 below is a newspaper article highlighting the problem of drug shortage in health facilities in the country, and quoting the Kilifi County Director for Health requesting the national government to intervene.

*Figure 12: Newspaper article highlighting the problem of drug shortage in the country*



### **8.2.2. Dialogue, consensus building and interim arrangements for EMMS management**

As the debate on EMMS procurement roles, process and composition of KEMSA raged on, a health sector Intergovernmental Relations Forum was convened to facilitate dialogue and consensus around these issues and to develop an interim action plan to address the drug shortage crisis that was being experienced in government health facilities across the country. During this dialogue process, the national MoH with support from health sector development partners, particularly the World Bank country office, provided funds to procure a six months EMMS buffer stock for all government health facilities countrywide. This was done to allow the county government to set up their structures and systems to take up this procurement role.

[... they (county facilities) actually got some free supplies from KEMSA worth of like 6 months' supply. These were provided by national government through the partners, World Bank etc, yes, because KEMSA also still had some of money for, old stock still pending and yet the issue of getting the supplies through the drawing rights had elapsed .....] KII N 002

[...Yes that actually it did happened. They called it a one-off supply so and actually from the circular that came from the ministry it was that, that stock was supposed to last facilities up to December to this (2013) December which is into the second quarter .....] KII C 004

In the meantime an agreement was reached following negotiation at the health sector intergovernmental relations forum, and counties agreed to procure their commodities from KEMSA to gain economies of scale and commodity quality assurance. The counties and KEMSA agreed on a 'service agreement' where KEMSA would service the orders from counties within two weeks of receiving them, and counties would pay for these commodities upon delivery by KEMSA:

[...The commodities (agreement) is almost by and large done because they (county governments) somehow unanimously agreed because of economies of scale they will be procuring from KEMSA and they had a meeting to agree on the service agreement and all that.....] KII N 004

### **8.2.3. Early outcomes of EMMS procurement and distribution process at county level**

The County Department of Health (CDoH) in Kilifi embarked on undertaking quantifications and ordering process for EMMS as from end of 2013 amidst several challenges. Some of the challenges faced at the time included the lack of appropriate technical and infrastructural

capacity at facility and county level to undertake the actual needs quantifications for the commodities, the lack of a Chief Officer in the CDoH who is the accounting officer in the department which meant that all facility level orders had to be taken to treasury for processing, and lack of clarity by health facilities on what form of supporting documents would be needed when making the orders. Because of these challenges, some of the managers at sub-county level felt that the process had become overly bureaucratic and this significantly delayed the ordering process.

[...And capacity in terms of technology, the IT, I'm currently using, my personal computer to do this quantification work for all the facilities....] KII C 004

[...a lot of bureaucracy like for example now I have gone to the county office more than six times they keep on telling me go and attach this other one I come back to Malindi go and attach this other one I come back to Malindi.....] KII SC 005

By December 2013, the county had made its first commodity orders to KEMSA for all the hospitals. However, given technical capacity challenges at the CHMT level to support the lower level facilities in placing their commodity orders in time, the supplies to health centres and dispensaries were delayed for several months. This meant that these facilities continued to operate for several months without any drug supplies after exhausting the buffer stock supplied by national MoH. This led to growing concerns and complaints by members of the public over the lack of drugs in the lower level public health facilities.

Eventually, the first tranche of hospital supplies procured by the county were delivered in February 2014. Hospital managers were much happier with the level of order servicing from KEMSA and they reported a higher order-fill rate on the supplies compared to the previous orders serviced by KEMSA in the old 'pull' system.

[...They (KEMSA) have now supplied so generally we are not badly off as a hospital. the refill rate almost to 95%. We did the quantifications that this is what we want and then we raised an LPO and actually they supplied most of the things we needed..., at the moment to me the challenges might be our speed of doing that work. But the structure itself can survive or can work for us....] KII SC 003

Though the supplies to lower level facilities were delayed, when they eventually arrived there too was a feeling by facility managers that the order servicing by KEMSA was better. In addition, the county government was able to procure drugs for all government health facilities that were operational within the county irrespective of their legal registration status. This was different from the old pull system where only facilities which had been legally gazetted were



allocated drawing rights for commodities by KEMSA. Considering that the gazettelement of health facilities used to be undertaken by national MoH, which would take up to several years from the time a facility is operational, many times health facilities used to exist without drawing rights allocations for drugs and other commodities. With the decision and choice on which facilities to include in the commodities allocation now happening at the counties, the process managed to address this long-standing bureaucratic problem.

The observed community involvement and participation in the whole process of EMMS management at the time was poor owing to poor capacity of most FMCs and facility managers over this highly technical process of commodity management.

[...So something that needs to be done as the health sector, we've always enclosed ourselves and worked within ourselves but we need to strengthen that community involvement from the facility management committee ...] KII C 004

#### **8.2.4. Politicization of EMMS management choices and processes in the counties**

As the counties took up the EMMS management function, there was a visible attempt by several counties countrywide to achieve political visibility over this role. First several counties in their initial days opted to procure ambulances which were perceived to be politically more visible in the eyes of the public and voters; at the expense of procuring essential drugs for their health facilities. One county for example was reported to have bought 70 ambulances (one for each of its electoral wards) at the time. This ambulance procurement craze by many counties was extensively covered by the national media at the time (Figure 13).

Subsequently, when the counties begun to procure drugs, from the general observations at the time, it became increasingly fashionable for governors in respective county governments to organize public rallies every time the KEMSA trucks carrying drugs for health facilities arrived, with a claim of officially 'flagging off' the drug supply. This subsequently turned what used to be a routine exercise of drug distribution to health facilities into a major political fun-fair in the counties under devolution (Figure 14)

Figure 13: Media coverage of counties procuring ambulances at the time

## Governor Alfred Mutua acquires 70 ambulances for Machakos County

Posted by Jambo on Wednesday, February 12, 2014 · 5 Comments



## Kisii County government launches new ambulances to improve health services



The County Government today launched five new ambulances to improve service delivery in the health sector.

## NANDI COUNTY BUYS SIX MODERN AMBULANCES



## Scandal of imported 'converted' ambulances

Motoring expert says illegal modifications will put lives of patients at risk.



Ambulances in a garage. Busia residents are furious over the death of an expectant mother as an ambulance driver failed to take her to a different hospital for failure to pay a Sh1,000 bribe.

Figure 14: Media coverage of governors 'flagging off' drug distributions

## Sh10 Million Medicine for Narok Health Centres



NAROK government has disbursed medicine worth Sh10 million bought from Kenya Medical Supplies Agency. The medicine will be distributed to all public hospitals, health centres and dispensaries in the county.



The flagging off was preceded over by H.E Jackson Mandago and the Chair of ICT committee in the Senate Hon Mutahi Kagwe who were visiting the country on other ICT matters.

## ELGEYO MARAKWET DEPUTY GOVERNOR FLAGS OFF DRUGS WORTH KSH 12.5 MILLION



Elgeyo Marakwet County has received drugs and medical supplies worth over Ksh 12.5 million from Mission for Essential Drugs and Supplies (MEDS).

## Kisii County Government buys drugs worth sh 54 million for local hospitals

Health facilities in Kisii County have received pharmaceuticals worth Sh 54 million. Governor James Ongwae today flagged off a consignment of pharmaceuticals to be distributed to Kisii Level Five Hospital and other health centres in the county.

Kenya Medical Supplies Agency (Kemsas) operations director Joshua Obell and Corporation secretary Fredrick Wanyonyi were present during the flag off ceremony at the Kisii Level Five Hospital.

Similarly, in Kilifi County, when drug supplies for primary facilities eventually arrived in the county, the county government hurriedly organized a public rally for the governor to flag-off the commodity distribution. At the same time the county also procured several ambulances to be based in every electoral constituency in the county. Figure 15 below are images from the governor's drug flagging off event.

*Figure 15: Images of the Kilifi County governor flagging off drug distribution; and the Kilifi county ambulances*

<https://www.facebook.com/officeofthegovernorkilificounty>

Office of the Governor- Kilifi County.

June 23, 2014 ·



Governor Amason Jeffah Kingi

I am joined by Hon Peter Shehe Mp for Ganze, Hon Mustapha Idd Mp Kilifi South and Hon Mbeyu MCA Kibarani as we launch the multimillion curative drugs project

The project will see all Hospitals, Dispensaries and Health Centres are well equipped with drugs and equipments to cater for the medical needs of our people



### 8.3. Summary

In summary, prior to devolution, KEMSA was responsible for procurement, warehousing and distribution of EMMS to all government health facilities. The 2010 constitution classified all EMMS managed functions (including those initially carried out by KEMSA) to be county level functions. Counties thus has the choice regarding what commodities to procure and where from. However, with the rapid transfer of the EMMS management function before appropriate capacity to undertake it had been built in counties, county governments were faced with a significant challenge in procuring EMMS resulting in health facilities suffering prolonged periods of time without these supplies.

By the time counties were in a position to procure EMMS, most focused on visible equipment like new ambulances. When drugs were procured, it became common for governors to be seen flagging off drug distribution to health facilities, illustrating the politicisation of what was a routine exercise. Nevertheless, sub-county managers reported a better order refill rate for

commodities procured by the county governments compared to the former pull system by KEMSA. In addition, county governments were able to procure and distribute drugs to all operational facilities irrespective of their gazettement status. This was an improvement from the old KEMSA system which required only gazetted health facilities to draw commodities from KEMSA.

## **Chapter 9: Discussion**

### **9.0. Introduction**

In this chapter, I present a general discussion and interpretation of the study findings. Using the thematic elements of my conceptual framework, and drawing from several theoretical frameworks, I demonstrate how the study findings relate to the elements of the conceptual framework and to the broader literature on health system decentralisation. I have organised this chapter in several sections. I begin by highlighting the study strengths and limitations; then progress to present an overview summary of the findings, followed by a discussion on how the broader political context in the country before, during and after the drafting of the 2010 constitution affected the implementation process of devolution in the health sector. I then discuss how decision space, organisational structure and capacity, and accountability - on paper and in practice - interacted with each other to influence the implementation and outcome of devolution within the health sector. I conclude the chapter by discussing how the concept of *power* - that emerged as an important theme all through the findings - stood out in influencing the implementation and outcome of devolution within the health sector.

### **9.1. Study strengths and limitations**

As highlighted earlier (chapter 4) I had multiple positions prior to and during the implementation of this study. Prior to conducting this study, I had a long history of ‘insider’ roles and involvement with the MoH both in Kilifi and at the national level. During the process of conducting this study, I was also co-opted into the MoH FACT team at national level that was charged with the responsibility of assigning and coordinating the transfer of functions to CDoH. In Kilifi, I continued to provide technical support to the CDoH in developing the County Health Sector Strategic Plan, and the CDoH AWP in subsequent years. This very strong ‘insider’ role potentially shaped people’s responses to me during data collection, and informed my interpretation of the data. However as explained in chapter four, I employed several strategies to understand and minimise potential bias, including the use of triangulation from multiple data sources, and regular self and group reflections with colleagues in the RESYST Learning Site [107, 116].

The embedded nature of this study, owing to my ‘insider’ position both at the national MoH and Kilifi County levels, and the nesting of the study within the Kenyan Learning site, facilitated access to individuals and in-depth learning, and enhanced the opportunity for the study findings to be regularly shared with relevant decision makers. This strengthened the

immediate policy relevance of the study, as the findings could be used to enhance the implementation of health sector devolution in Kenya in real time and in appropriate ways, contributing to meeting specific objective 3 (see section 9.8).

However, this study was not without limitations. First the timing of the data collection, during the early days of devolution implementation, meant that a lot of the effects were still unfolding. The findings therefore only relate to the early health system effects of devolution in Kenya, and not how devolution generally affected the health sector over time. For example, a major finding of the study was the transfer of health sector functions to county level before establishment of county level structures. By the second and third year of the existence of the county governments however, some of the essential county level structures had been established. Nevertheless, the study findings are still important and useful because understanding the effects on and functioning of the health system during such radical change will have important lessons for other health systems planning devolution or other large scale changes. Moreover, the changes observed during these early days of devolution point to important issues that may persist in to the medium term and require further attention e.g. whether there will be recentralisation of financial control, or what the consequences will be for the nursing and medical professions in terms of recruitment, retention and job progression. Finally, it would be naïve to consider that health systems are ever static – in fact they are usually undergoing some form of change, albeit rarely as radical as this. This means that as researchers we have to grapple with the issue of studying systems that are constantly changing [74].

Secondly there was lack of pre and post-devolution quantitative data for comparing and triangulating the observed and perceived effects of devolution in the health sector. Quantitative data on e.g. health services utilisation, commodity stock-outs and health worker retention, both before and after the implementation of devolution would have been useful to quantitatively assess the effects of devolution on the health sector. However, the health system did not maintain reliable quality data on these aspects prior to devolution; and this study being conducted in the first year of implementation of devolution, meant that the less than one-year post devolution time span was not sufficient to have collected meaningful quantitative data on these indicators, which could be linked to the devolution process.

The focus on only one county could be considered a third limitation of the study. However, the decision to use one county was deliberate, as it allowed for a deeper exploration of the issues under focus within the study, by involving a broad range of stakeholders. Kilifi County is also part of the health systems governance learning sites for the RESYST consortium, within which

this study was nested. This will allow for a longer term tracking of the decentralization effects in this sites beyond the time period of this study

## **9.2. Summary of key findings**

In August 2010, the country through a popular public referendum voted to adopt a devolved government structure with semi-autonomous elected county governments directly accountable to the electorate. The coalition government at the time was to embark on a two-year preparation for devolution by establishing the required county level structures. The government was also to establish and build capacity of different institutions that would be necessary for the establishment of county governments, and a smooth transfer of county level functions from the national government. However, the coalition government was going through a period of political wrangles and squabbles over several issues around the constitutional implementation. These wrangles caused a significant delay in the setting up of structures necessary for facilitating devolution. This meant that by March 2013 when the county governments were elected into office, most county structures and national level institutions required to facilitate the induction of the county governments and smooth transfer of functions were not in place.

The election results of March 2013 saw the *Jubilee coalition* (which during the campaign period had been portrayed as anti-devolution) win the presidency and the majority of seats in both houses of parliament. The Coalition for Reform and Democracy (*CORD*) coalition on the other hand which had branded and marketed itself as pro-devolution won the majority of the governors seats across the country. Given this situation, when the governors came into office, they demanded that the national government hand over immediately all functions designated for the county governments. With the increasing political pressure from the governors, the president in June 2013 directed that all county functions be transferred immediately to county governments and budgets there-in allocated to them.

This presidential directive happened at a time when most county governments had not set up their structures. They were thus unable to adequately handle these functions, leading to major disruption in most government functions and services, and particularly health services. In the health sector at the county level, this rapid transfer of functions caused major challenges in overall health sector planning, budgeting and financial management, the management of HRH, and the management of EMMS.

On overall planning and budgeting, the national government allocated the county governments their non-conditional allocations from the equitable share of revenue and the equalisation fund. In Kilifi County, the lack of definitive structures and non-clarity of roles within the County

Department of Health (CDoH) meant that the department was unable to participate fully in the planning and budgeting process in the 2013/14 fiscal year. This forced the county treasury in Kilifi to conclude the budget process by allocating the CDoH an amount based on historical records of allocation and expenditure. The early days also experienced other problems including perverse re-centralisation of financial management roles from the sub-county and health-facility levels to the county level, and hospitals being unable to utilise the user fees which they were collecting due to the lack of an appropriate legal framework to enable this. There were also persistent disagreements and contestations between the county government and the national government over mechanisms for channelling health sector related conditional grants.

On HRH management, the rapid transfer of functions before counties had established their HRH management structures meant that they could not undertake key HRH management roles, notably payment of salaries. An interim agreement was arrived at where national MoH continued to pay staff salaries up to December 2013, and invoiced county governments for reimbursements. When the counties eventually took up this role, payment of staff salaries was often delayed, with numerous pay-roll inconsistencies and discrepancies; some staff were totally missing from the payroll. There were also some reported cases of political interference in HRH management across the country. Overall, the health sector faced significant lack of clarity over key HRH management roles including management of inter-county transfers, in-service training and career progression for health care workers. All these challenges led to observed and reported mass resignations of health care workers across the country, and a health workers' long protracted strike that crippled the health sector country-wide in late 2013.

Similarly, the EMMS management function was affected by the rapid transfer of functions from national to county governments. In the early days after devolution, there were arguments and contestations between national MoH and CDoH country-wide on the role and composition of KEMSA. In the interim phase, national MoH supplied six months' worth of buffer stock of drugs for all public health care facilities countrywide. When the county governments eventually took up this role, there was widespread politicisation of the drug and commodities procurement and distribution within the health sector. Nevertheless, health facilities reported better fill rates whenever drugs were supplied.



### **9.3. The broader Kenyan context and its implications for the design and implementation of devolution**

Walt and Gilson (1994) argued that the understanding of context is an essential element in policy analysis [15]. Within the context of decentralisation, this argument has been further advanced by several authors who have stressed that the implementation and outcome of a decentralised system in any setting is highly context specific [4, 8, 11]. Omar (2002) argued that the ‘political drivers’ and political context that push a country to adopting a decentralised governance arrangement have a major bearing on how decentralisation gets implemented in a given setting [4]. Omar’s (2002) assertion is particularly plausible because decentralisation involves the shifting of power and control from the centre to the periphery, making it a highly political process in its own right [10].

With regards to the design and content of the decentralisation model as presented in the constitution of Kenya 2010, the decentralisation journey in the country has been a long and tortuous one. This journey saw the country adopt a federal system of government at independence, revert to a unitary government system two years later in 1965, introduce local authorities in 1977, strengthen the district system in early 1980s, and then finally adopt a devolved government system in a public referendum which introduced county governments from early 2013 [33, 79, 80, 86, 87, 96, 122]. All through this journey, the strongest push for decentralisation in the country has been an internal ‘bottom-up’ pressure from the general population particularly from certain regions of the country that have been clamouring for equity, fairness and inclusion in the distribution of national resources and management of public affairs [86, 96, 131]. The adoption of a strong devolution model, with significant county level autonomy and discretion in decision making for resource allocation can thus be understood from the background of the need and push for an equitable regional balance in the allocation and use of public resources. In their analysis of Kenya’s devolution, D’Acry and Cornell (2015) argue that the government’s historical marginalisation of certain communities and regions in the allocation of public resources, coupled with a high level corruption culture in government, gave rise to a push for an ‘*everyone’s turn to eat*’ model of government within the 2010 constitution [86].

With regards to the understanding of context for the implementation of the devolved government system, Odhiambo (2013) argued that for one to understand the ongoing political unfolding around the implementation of devolution in Kenya, one ought to understand the country’s political history [132]. The political history and context of Kenya is comprehensively

covered in chapter 3 of this thesis; and important elements of this history which underlie the overall goals of devolution are covered in chapter 5. In summary, key features of this historical background include the political heritage of the main political parties and key political actors in the country over time, the perceived injustices and inequalities across different tribal and geographical populations, and the experience of political violence especially after the 2007 general election.

Leichter's (1994) framework [69], can be used here to provide a better understanding of the political context in Kenya within which the devolution was designed and implemented. Structurally, Kenya has had different forms of decentralised government systems since independence ranging from a federal system, to local authorities and deconcentrated districts units [33, 82, 87, 132]. However these decentralisation efforts did not serve to address the needs for inclusivity in public resource sharing, and peoples' participation in public governance, hence the continued push and subsequent adoption of devolved governments with a significant level of local autonomy in 2010 [86, 96]. The continued perceived authoritarian and discriminatory KANU regime, the promise for a new constitution by NARC in 2002, and the divisive election and subsequent violence of 2007 all created political situational factors that served to fuel the sustained push and demand for a devolved system of government and its subsequent adoption in the 2010 constitution [86, 92, 123, 133]. Culturally, the country has had deep rooted tribal inclined political ideologies [83]. This tribal political inclination for example saw the populous Kikuyu community partner with an equally populous Kalenjin community to form the Jubilee coalition which went on to win the presidential election in 2013 [88, 134]. The country has also been characterised by corrupt practices of the government system over the years [86]. The tribal political culture and corrupt government practices, though seen as negative traits, indeed did serve to sustain the demand and push for a devolved government system [86]. Finally on Leichter's environmental factors; the continued external pressure on the Government of Kenya (GoK) particularly from external development partners to adopt better forms and practices of governance; coupled with the Pan-African mediated peace and reconciliation talks to end the post-election violence of 2007/08 also served to add onto the push and subsequent adoption of devolved government system in Kenya [86, 133]. In summary, Kenya's political history serves to explain why and how the country resolved to adopt a devolved government system in 2010 and also partly provides an understanding of how and why the early implementation processes of the devolved government system happened.

As regards to the role of key actors in influencing the design and early implementation process; there are key individuals, groups of individuals and institutions who have shaped the decentralisation debate in Kenya over time. The Kenyatta family for example represented in the country's political memoirs by *Jommo Kenyatta* and *Uhuru Kenyatta*; and which has been in power for many years, has been seen and perceived to have a capitalistic ideology which served to entrench government marginalisation of other communities and regions, and hence was seen to be anti-devolution. Meanwhile the Odinga family, represented by *Jaramogi Odinga* and *Raila Odinga* have historically been perceived to be socialistic and pro-devolution [83, 86, 132]. During the 2013 election campaign the *CORD coalition*, led by *Raila Odinga*, which styled itself as pro-devolution, branded the Jubilee Coalition as anti-devolution simply because Uhuru Kenyatta who was the leader of the Jubilee was a son of *Jommo Kenyatta* who was seen to have engineered the many years of KANU led marginalisation [86, 88, 134]. CORD also argued that *William Ruto*, who was *Uhuru's* presidential running mate on the Jubilee ticket, had opposed the constitution in 2010 and was thus an enemy of devolution [86]. This meant that even though they won the presidential election together with an outright majority in both the National Assembly and Senate; the *Jubilee coalition* suffered a legitimacy image problem as far as its commitment to implement devolution was concerned [86, 134]. This legitimacy challenge of the *Jubilee* leadership partly explains why, when the county governors (the majority of whom were from *CORD*) demanded for the immediate transfer of county functions just after the election, the president was quick to agree even before county structures were established; he feared his government would be branded anti-devolution, and was keen to regain legitimacy [86]. The Transition Authority (TA) was a key institution to the smooth implementation of devolution [125]. However, because of the mistrust between political actors, the TA was constituted late, and was thus unable to adequately carry out its mandate of establishing and building capacity for county government structures.

With regards to the implementation process of the devolved government system, the complex interplay of key political actors and institutions in a context of political mistrust and power struggles led to a fast-tracked transfer of county level functions, way before all the necessary county government structures had been established [86]. This fast-tracked transfer to a great extent explains the early outcomes and effects of devolution, particularly within the health sector.

In conclusion, it is quite evident that the broader political context of Kenya, largely affected and influenced the design and implementation of devolution in the country generally and within

the health sector specifically. This finding largely agrees with Omar's (2002) assertion that decentralisation is always a political rather than a technical managerial process and its design, implementation, and outcomes should always be understood in that context [4].

#### **9.4. Government organisational structure and capacity under devolution**

An understanding of the structure and organisation of the government system is critical in the analysis and understanding of the decentralised system [11, 30]. Applying the *public administration framework* as described by Rondinelli and Cheema (1983) to examine the government structure in Kenya, we see that prior to the enactment of the 2010 constitution, the country had a unitary government system with *deconcentrated* units [9, 80, 87]. These units at provincial and district level were composed of government bureaucrats, in-charge of respective sectors and appointed by the national government in Nairobi. They mainly served to manage and coordinate the implementation of government services within their jurisdiction [82].

The country's 2010 constitution introduced a *devolved* government system with national and county level governments both directly elected by the people [33, 86]. The national government comprises of three arms. An executive arm is headed by an elected president and deputy president, with an appointed cabinet. A legislative arm comprises the Senate and the National Assembly, both of which include members elected directly by the people, or nominated by political parties to represent special interest groups based on party strengths. The third arm is the judiciary headed by the chief justice, which comprises the supreme-court, the high court of appeal and all other lower level courts [33].

The county government is made up of two arms. First is the executive headed by an elected governor, his deputy, and a ten-member County Executive Committee (CEC). The other arm is the legislature which comprises of Members of County Assemblies (MCAs) either elected directly by the people from each electoral ward, or nominated by political parties to represent special interest groups [33, 34]. Each CEC member is in-charge of a county department. One such county department is the County Department of Health (CDoH) which is responsible for undertaking all the county level health sector functions [34].

Pratt and Zechauser (1991) described the *principal agent framework* (discussed in chapter 2) which they subsequently used to assess choices made by private sector managers [29]. This framework has been used for studies of decentralisation aimed at assessing the range of decisions that a principal (central entity) transfers to an agent (peripheral entity) [3, 27]. Bossert (1998) subsequently adapted this framework to develop the decision space theory, which

further seeks to assess and understand the choices made by managers in decentralised health systems within their mandate as outlined in legal and regulatory frameworks.

In applying the *principal agent framework* to understand the organisation and functioning of the evolving health system structure in Kenya, one can see that under the old system there existed one ‘principal’, the national Ministry of Health (MoH). The ‘agents’ were the PHMTs at provincial level or DHMTs at district level. The ‘principal’ (national MoH) appointed and assigned roles to the ‘agents’ (PHMTs and DHMTs) and held them accountable for these roles. The DHMTs were largely responsible for the day-to-day management and coordination of health service delivery within the district [99, 101]. Under the devolved government system, however, the CDoH (the ‘agent’ responsible for the actual management of health service delivery at county level) now has multiple ‘principals’: 1) the national government MoH, to which it is accountable for ensuring adherence to national health policies and overall strategic objectives; 2) the county government executive and county assembly to which it is accountable for the use of resources and local county level policies and priorities including political interests and; 3) communities for ensuring availability of essential health services [9, 34, 38].

In his analysis of frameworks for studying health system decentralisation in developing countries, Bossert (1998) argued that health system decentralisation of the devolved type, where there are multiple principals, can lead to conflicts. Local health system managers often find themselves having to balance the interests of the local level principals with those at the national level; the two of which are often in conflict [11]. The findings of this study largely agree with this assertion. From the study findings, in preparation for the transfer of health delivery functions to counties, the national MoH through the Functional Assignment and Transfer (FACT) policy gave a recommendation of a generic structure for CDoHs, and also recommended and outlined a three year plan for phased transfer of the health delivery coordination functions [38]. Most counties though due to local county political interests largely ignored the recommended CDoH organisation structure. Secondly, the county executives through the Council of Governors (CoG) demanded for the immediate transfer of all county level functions including the health functions; thus making the CDoHs take up functions for priority setting planning and budgeting, HRH and EMMS management functions, even when they were not adequately prepared to do so. On health sector resource allocation for example, the national government (represented by national MoH) disagreed with county governments on the mechanisms for channelling HSSF funds to primary health facilities thus significantly delaying the release of these funds and affecting the operations of the CDoH. On HRH

management, we see that some counties rejected doctors posted to them by the national MoH. Similarly, on EMMS management, we see that county governments resisted initial attempts by national MoH to have all their EMMS supplies procured from KEMSA.

Several authors have argued that the ability of decentralised health units to deliver on their assigned roles - and hence harness the benefits of decentralisation even in the face of multiple principles - largely relies on their organisational capacity [1, 8, 11, 30].

I used the UNDP capacity assessment criteria to assess the early outcome of devolution of health service delivery functions, in Kilifi County. *On capacity level one (system level)*, the CDoH had the legal mandate to undertake the health service delivery at county level [33, 34]. From a technical policy perspective, the Kenya Health Policy (KHP) 2012-30 and the Kenya Health Sector Strategic Plan (KHSSP) 2012-2017 provided the broader technical policy guidelines for undertaking the health service delivery roles. These included guidelines for organisation of CDoH coordinating structures, planning and budgeting guidelines for the county health services and the organisation of county health service delivery levels of care including care referral guidelines [37]. I also found that other county level institutions and organs like the County Public Services Board (CPSB), and the County Treasury and County Assembly, that were meant to facilitate the CDoH planning process, lacked the capacity to do so.

On *the UNDP capacity level two (institutional level)*, we find that during the 2013/14 fiscal year planning and budgeting process, the CDoH did not have a clearly defined mission and strategy. It also lacked a clearly defined organisational structure and clear mandates for the different interim structures within it. There was also lack of clarity between the roles of county treasury *vis a vis* the CDoH in the planning and budgeting process. This was largely occasioned by the delay in the appointment of senior statutory department managers and by the CDoH not having developed its five year strategic plan by the start of the planning cycle. This partly explains the lack of involvement and participation by the CDoH in the budgeting process during that financial year.

On *capacity level three (individual level)*, the results reveal a significant lack of capacity for planning and budgeting roles of most individuals within the County Health Management Team (CHMT). This was because the interim CHMT members were largely appointed from the former PHMT and DHMT structures which did not have a strategic planning and budgeting role for most key functions including HRH and EMMS management. There was also lack of

clear job descriptions for the CHMT members and no formal induction for their new roles at the county level.

Other county level structures that were meant to facilitate and complement the CDoH were also weak in capacity level 3. The CPSB for example had just been appointed and lacked the staffing and other infrastructure needed to undertake the human resource management function at the county level. The County Treasury was understaffed and as a result we see a significant delay in financial management processes and procedures, including procurement process at the county treasury, affecting the operations of the CDoH. The MCAs lacked the basic education and knowledge required to comprehend and understand their oversight and provide a community voice role in the planning and budgeting process, thus they were stuck with the plans and budget proposals sent to them for approval by the executive, without knowing how to proceed with them. As a result the county executive resorted to giving incentives to the MCAs such as calling them for meetings and paying them allowances so as to induce them to approve the executive's proposals on budgets and financial plans without questions.

A complementary framework to examine organisational capacity was proposed by Aragon (2010) [71]. This framework has recently been used by Elloker et al (2013), and is gaining popularity by health policy analysts in assessing sub-national level health management units, especially in developing country contexts [72, 73, 108].

In applying the Aragon framework as an additional lens to consider the capacity of the Kilifi CDoH, we find that the department had good hardware elements including physical infrastructure for delivering health services and a good financial resource allocation in 2013/14. However, during that year, the department's tangible software elements were significantly lacking. There was no clear organisational structure with clear mandates and roles, and only a few interim CHMT members had the knowledge and skills required for the strategic planning and budgeting roles in the CDoH. In addition, by the time of the 2013/14 fiscal year resource bidding process at the county level, the CDoH did not have a sector strategic plan and an Annual Work Plan (AWP), both of which are essential tangible software elements required to influence and facilitate the resource allocation at county level [72].

In terms of intangible software, we find that the CDoH lacked the necessary power, appropriate relationships and communication capacity to influence the process of transfer of health service delivery functions to the county level. This resulted in the political players especially at the county level pushing for and demanding the transfer of the functions to the CDoH even before it had the proper structures and capacity to take up these functions. Within the CDoH however,

we find that amidst the chaotic transition to county government process, the sub-county level managers played a crucial role in providing reassurance and hope for the facility level managers, even during a time of disruption in flow of resources to health facilities [73]. This role played by the sub-county managers is as a result of their well-established intangible software elements such as communication skills, the type and quality of relationships that they had established over time with frontline facility managers; and their routine work norms including facilitative supervision visits and regular review/feedback meetings with facility in-charges which supported resilience among facility in-charges. This supported the continued opening of facilities even during the most chaotic times of transition, and illustrated health system capacity and resilience to cope with externally exerted stress as has been observed in other settings [72].

In conclusion, these findings support Omar's (2002) assertion that health system decentralisation always brings additional responsibilities including of planning and resource allocation to local decision makers, yet their capacity for undertaking these responsibilities is often lacking, and often ignored during the design of decentralised systems [1, 3, 4].

### **9.5. Decision space over resource management under devolution**

Over the years, some have argued that decentralisation enhances public sector management efficiency through ensuring decisions about resources are made closer to where the needs are, which in turn addresses the challenges of centralised health sector resource allocation and planning [8, 9, 11, 20]. This argument views ideal health system decentralisation as one that provides more decision autonomy to the peripheral units over health sector resource allocation [11, 30]. However, other commentators have argued that the health delivery function is highly technical and that excessive transfer of autonomy to peripheral units can easily reverse gains, or digress from national health priority goals [1, 3, 28].

The principles of the *original principal-agent framework* and Bossert's *decision space framework* (discussed in chapter two and mentioned earlier in sections 9.4 of this chapter) can be applied to help understand the mandates and choices made by different players in Kenya over health sector resource allocation, planning and budgeting in the 2013/14 fiscal year. In summary and as discussed in chapter 6, in relation to general resource generation and allocation, the national government has the responsibility to generate national revenue and allocate some of it to county governments [33, 35, 124]. The national government allocation to counties is in the form of the non-conditional (block-grants) allocation from the equitable share, and the equalisation fund share for marginalised counties. Additionally, there can be



conditional grants for certain nationally identified priority sector projects including health, whose execution mandate is that of the national government. The conditional grants can only be allocated over and above the non-conditional allocation [33, 124]. From the findings of this study, we see that in the 2013/14 fiscal year the national government, in addition to the block grant to counties, allocated additional funds for financing health services at county level targeting the implementation of the presidential directive on free primary health and maternity services in all public health facilities.

At the county level, the county government has the mandate of levying certain county level taxes which together with the county allocation from national government is managed as the total county revenue [34, 35]. During the county planning and budgeting process, the different county departments, including the CDoH are supposed to use their annual priorities as indicated in their Annual Work Plans (AWPs) to compete for this county revenue in a bidding process that is coordinated by the county treasury [35]. From the findings of this study we see that during the 2013/14 fiscal year the CDoH did not participate in the resource bidding process at the county level. This forced the county treasury to allocate the CDoH resources based on historical allocation and expenditure records. The reasons for the CDoH non-participation in the resource bidding process were due to lack of significant tangible software capacity elements including lack of a clear organisational structure, and key offices required within the structures required to facilitate the department's budgeting process, and lack of a strategic plan and AWP to guide the annual sector priorities. This lack of appropriate capacity reduced the CDoH's ability to influence the amount of resources allocated to the health sector, thus reducing its decision space over resource allocation [11]. These findings are consistent with an argument advanced by Bossert and Mitchell (2011), who from their findings in a study to examine peripheral level decision space over resource allocation in Pakistan, found that the organisational structure and capacity of decentralised health units always affected the decision space of these units [30].

Within the CDoH, the CEC member for health and the Chief Officer for the department working with the CHMT have the mandate of identifying annual sector and departmental priorities during the development process of the AWP. It is envisaged that the budgetary allocation to the department would be further distributed along budgetary line items in accordance with these priorities. It is during the development of the AWP that the CDoH determines the amounts to be allocated along the expenditure line items including allocations for HRH, EMMS and for other development and recurrent costs within the department [23,

35]. In line with the spirit of decentralisation within the 2010 constitution, county departments are mandated to further decentralise decision making particularly of planning, budgeting, and co-ordination and including financial management related to day-to-day service delivery to sub-county management entities [34].

From the study findings (chapter 6), first the lack of participation of the CDoH in the resource bidding process for the 2013/14 fiscal not only reduced the ability of the CDoH to influence the total amount of resources allocated to the department, but also the allocation along line items. This reduced the CDoH decision space over the resources allocated to them. Even after the budget had been allocated, the CDoH was unable to immediately take up certain decentralised mandates like payment of health worker salaries and procurement of EMMS (chapters 7 and 8). This forced the national MoH, through the health sector inter-governmental relations forum, to put in place interim arrangements for managing both health workers' salaries and procurement of EMMS. Furthermore, the lack of appropriate structure within the CDoH meant that the department could not further decentralise its coordination and operational management roles to sub-county units including the hospital and sub-county management units. Subsequently all the hospital and sub-county management teams had to send in all of their requests for any purchases and expenditures to the Chief Officer at the county headquarters, causing a significant delay in implementation of planned activities. This happened even though before the implementation of county governments, district and hospital management units had a delegated accounting mandate and managed their local budgets for operational recurrent expenditures.

However, as described in chapter 8, the findings of this study present some early positive effects of increased county level decision space over EMMS management functions. The findings report the observed ability of county government to procure supplies for all operating facilities irrespective of their gazettement status, hence increasing access to health services. There were also reports of better fill rates for supplies by facility level and sub-county managers.

These observations highlight the necessity for proper and appropriate structures and capacity at peripheral level in decentralised health systems, if they are to succeed in taking up the functions mandated to them (as discussed in section 9.4). These findings are consistent with the arguments advanced by Bossert and Mitchell (2011), and Omar (2002), who stressed the need for appropriate capacity of decentralised health units, if the increased decision space for health system decentralisation is to be meaningful [4, 30].

## **9.6. Accountability structures and practices under devolution**

One of the most common reasons for the promotion of public sector decentralisation is the belief that it enhances accountability largely through supporting community participation in decision making [18, 20]. Public participation in public sector governance can be exercised directly by the people, or through their representatives [67]. Brinkerhoff (2004) developed a framework for assessing health system accountability that defines accountability in the health system as a form of answerability or sanctions, and that distinguishes between financial, performance and political forms of accountability [18].

Brinkerhoff's accountability assessment framework can be applied to provide a better understanding of the proposed public accountability structures under devolution in Kenya, and how they functioned within the 2013/14 fiscal year. At the national level, parliament (National Assembly and the Senate) is the main accountability organ. The National Assembly has the mandate of holding the national government executive accountable over all its financial, performance or technical decisions. The Senate on the other hand has the mandate of holding the national government accountable over financial and political decisions it makes that have a direct effect on county governments. The Senate also has an additional mandate of holding county governments accountable over the use of their financial resources [33]. In addition any citizen has a right and opportunity to directly participate in government decisions through organised public forums as with the public hearings during the annual budget making process [33, 35]. Citizens can also directly question government decisions by petitioning through parliament or the judiciary [33].

From the results of this study, we see that in the 2013/14 financial year, as required by law, parliament had to approve the proposed national budget once it had been approved by the cabinet. Similarly, during the appointment of senior government officers, the president nominated them, and they had to be vetted by the National Assembly before being appointed. In both instances parliament invited direct public participation in both the budgetary making and the vetting process. However, these accountability procedures, and especially the vetting process, was viewed by many as largely a public relations exercise; MPs were not perceived to have the required capacity to appropriately vet the nominated senior public officers.

At the county level, the County Assembly is the main organ that offers financial and political accountability oversight of the broader county government [34]. As with National level, the County Assembly is mandated to approve the broader county budget once it has been developed by the county executive, as well as vet senior county government officers before

they are appointed by the governor [34, 35]. The national treasury through the office of the comptroller of budgets also has a financial accountability oversight role for all accounting units including county governments. In this role, the comptroller of budgets is charged with the responsibility of ensuring that accounting units adhere to budgetary guidelines issued by treasury every year [35].

MCAs in Kilifi County were perceived to lack the technical skills and knowhow to adequately interrogate the budget before discussing and approving the County Integrated Development Plan (CIDP). In this situation, MCAs were unable to exercise their accountability role, undermining the functioning of the accountability mechanism. However, we also see the national treasury's comptroller of budgets refusing to approve county budgets because of their non-adherence to budgetary guidelines on the percentage allocation between recurrent and development expenditure. The national treasury budget guidelines restrictions for accounting units including county governments, to an extent restricted the budgetary decision space for county governments. In both these examples, we see how a public accountability mechanism interacts with, and is affected or affects, organisational capacity and decision space. These interactions are consistent with the study conceptual framework, and agree with the findings of Bossert and Mitchell (2011) in their Pakistan study [30].

The CDoH in its mandate for strategic visioning, planning, budgeting and ultimate delivery of health services at county level is in theory supposed to be accountable to: 1) the national MoH for technical policy matters, 2) the broader county executive and County Assembly for performance, financial and political matters, and 3) directly to the communities for availability of essential health services [34, 37, 38]. In practice however, we see that the national MoH had a very weak capacity to demand for information and hold the respective CDoHs accountable in adhering to national MoH policy guidelines. The CDoH would often adhere to the broader county government's accountability demands over the national MoH as the broader county government had more power and stronger capacity to demand for information and hold the CDoH accountable [18]. This emphasizes the existence of multiple 'principals' acting on the CDoH as an 'agent' as earlier discussed in section 9.4. For example, we see that though the national MoH FACT policy did have clear guidelines for the preparation to be undertaken by the CDoH before the transfer of functions, when the county governments demanded for the immediate transfer of functions, the CDoH had to take up the health sector functions before they were ready to do so. Another example is when the national MoH posted out to counties newly-qualified doctors based on needs, some counties rejected these doctors on account that

they were not indigenous to those counties. In both these examples, the national MoH did not have strong capacity to apply sanctions on the CDoH.

From these study findings, we see that a key effect that devolution had on the health sector is that of increasing of political accountability at different levels, more than technical/performance and/or financial accountability [18]. At the national level, we see the president in a bid to maintain political legitimacy, succumbed to political pressure from the Council of Governors (CoG) and directed that all government functions, including health services earmarked for counties in the constitution, be devolved. This directive was executed with total disregard of the FACT policy guidelines that sought to guide establishment of CDoH structures, and build their capacity before transferring the functions [38]. At the county level the early days of devolution witnessed counties prioritising politically visible projects like mass procurement of ambulances at the expense of technically viable but less visible interventions, particularly Primary Health Care (PHC) services. This observation of counties prioritising visibly curative services, at the expense of PHC services, is consistent with observations made in Uganda and in The Philippines [42, 45]. The emphasis of political accountability by different health sector actors, at the expense of technical and financial accountability underpins the assertion by several authors that decentralisation is more of a political process than a technical management process, and its outcomes and effects in the health sector should always be understood in that light [4, 8, 135].

### **9.7. Power, contestations and actor relations under devolution**

Within the health sector, several health policy analysts have argued that power, which is basically defined as the ability to influence other actors, is a key determinant of the processes of health policy formulation and implementation [12, 68]. The notion of power in policy formulation and implementation is however a complex one to analyse as it often presents in many forms, characterised by actions or inactions by different actors in the policy processes [136]. Across this study, power and contestation emerged as a common theme. Analysing these power dynamics thus provides an additional lens for understanding the early outcomes and effects on the health sector of Kenyan devolution. In this subsection, I draw selected examples from the different tracers to illustrate how power dynamics shaped the devolution implementation process in Kenya. To do so I draw on VeneKlasen and Miller's (2002) *expression of power theory*. These authors have argued that during policy and political processes, power is expressed in four main forms namely; *power over*, *power to*, *power with*; and *power within*. *Power over* views having power involving taking it from someone else, and

then, using it to dominate and prevent others from gaining it, *power to* views power as a unique potential of every person to shape their life and world, *power with* concerns the ability to find common ground among different interests so as to build collective strength, and *power within* views power as a person's sense of self-worth and self-knowledge [76].

In terms of the broader context highlighted in chapter 5, once the new governors had been elected and sworn-in, they started accusing the national government and the Transition Authority (TA) of deliberately delaying and slowing down the process of facilitating the transfer of functions meant for counties. To this end the governors acted together to exert their *power with*, under the umbrella of the CoG, to influence and control public opinion and perceptions on the perceived threat to devolution being imposed by national government and the TA [76, 136]. The governors also in a bid to symbolically demonstrate their political/positional power within, demanded to use the title 'Excellency' and fly the national flag on their official vehicles. This move triggered a series of political power battles between the governors and other political players and led parliament to enact a political pecking order law that ranked the governors below the senators. The senate used its *power over*, in an attempt to impeach one governor in his first year in office for an alleged misuse of public resources in his county, but this move was seen by many political commentators at the time to be a malicious act of expression of power by the senate rather than an act of accountability.

On resource allocation, planning and budgeting at county level, the study findings reveal how the county treasury in Kilifi, exercising its *power over* and *power to*, directed the relatively powerless CDoH to close down the individual hospital bank accounts for user fees and deposit all the user fees collected in these facilities into the consolidated county revenue account. Although the CDoH did not agree with this directive and did not close the accounts, they still could not access and use the money from the account, as they would have needed permission to do so from the county treasury which had *power over* the CDoH on finance management matters. Another illustration of power dynamics over resource allocation, planning and budgeting is where the national treasury through the office of the comptroller of budgets exercises its *power within* and *power over* to avoid approving county government budgets in order to compel them to adhere to general budgetary policies and guidelines set by the national treasury.

On HRH management, we see the health care professionals who had traditionally always exerted their technical *power within* to shape major policy decision making within the sector, lose power to influence the implementation process of health sector devolution to the political actors [8]. We also see that when the health workers eventually went on strike to contest the

implementation of health devolution, their action did not obtain any public support, as the general public's thoughts and perception of devolution had already been shaped by the county governments [136]. Moreover, several county governments used their *power over* to threaten the striking health workers, including sacking some. Health workers subsequently called off their strike. This observation of healthcare worker loss of power during the implementation of health sector decentralisation and their reactions including strike actions is consistent with observations made in Nepal, the Philippines and in Uganda [42, 58, 63].

On EMMS management, the findings reveal that in exercising their new *power within* on EMMS management, counties decided to procure supplies for all public operating health facilities within their jurisdiction irrespective of their gazettelement status thus increasing access to service delivery within their areas. Furthermore, the counties also managed to negotiate with, and compel commodity suppliers, and particularly KEMSA to send them supplies as per demand. This led to a reported increase in order fill rates in health facilities.

## **Chapter 10: Study Practical Applications and Policy Implications**

### **10.0. Introduction**

In this overall conclusion chapter, I begin by making a specific note to highlight how the design and conduct of this study contributed to enhancing the implementation of devolution laws within the Kenyan health sector. I later revisit the health sector decentralisation debate, and provide insights for policy considerations whenever discussions about what health sector functions should be decentralised and which ones should not. I then summarise the overall study conclusions, before highlighting how this study achieved its intended aims and objectives; and finally conclude the chapter by drawing specific recommendations for policy makers, and suggestions for further research.

### **10.1. Contribution into enhancing the implementation of devolution within the Kenyan health sector**

Having been developed with a specific objective to draw on the empirical data and literature on good governance and accountability to identify strategies for enhancing achievement of decentralisation goals within the health sector, this study was specifically designed and executed with the intent of providing positive real-time contributions to the implementation of devolution within the Kenyan health sector.

First, this study was deliberately embedded within the MoH (at national level) and CDoH (at county level). Annex 7 provides an illustration of my personal, and that of other learning site researchers' embedded positions within the Kenyan health sector environment. This embeddedness, thus facilitated the ability for the study findings to significantly contribute to; and provide a broader understanding of the political context in Kenya, and assisting with the implementation of the decentralisation laws within the health sector at both national and county levels. At the national level for example this study was embedded in the devolution process through my co-option into several national MoH technical working groups, key among them being the MoH policy and planning Technical Working Group (TWG), and the MoH Functional Assignment and Competence Team (FACT) that was unbundling the health sector functions for both national and county level and facilitating the smooth transfer of functions to county level. This position provided me with an opportunity to feedback my study findings in real time to these key health sector technical teams and thus enhancing the implementation process for health sector decentralisation (annex 7).



Within Kilifi County, this study was embedded in the CDoH by being nested within the health systems governance ‘learning site’. This study approach ensured regular and continued engagements with county level decision makers to share study findings, and learn from the findings to institute measures to strengthen the functioning of the CDoH [72, 108] (annex 7).

The embeddedness of the study facilitated its ability to improve and strengthen the implementation of devolution processes in the health sector at county level around the specific study tracers. On resource availability and financial management for example; with the continued feedback and support to both the Kilifi CDoH and County Treasury, during the 2014/15 fiscal years, the CDoH managed to develop its AWP on time and thus had a better participation in the general county planning and budgeting activities for the 2014/15 fiscal year compared to the 2013/14 fiscal year. In addition, after sharing the plight and challenges facing the management of user fees in hospitals with several county level stakeholders including the CDoH, County Treasury and MCAs; they all came together and embarked on developing a county level legislation, dubbed the *Kilifi County Facility Improvement Bill 2015*, that sought to establish a county specific ‘Hospital Improvement Fund’ within which the user fees would be deposited and to allow the CDoH to utilise these funds without having to sort for further permission from the County Treasury [137].

On HRH management, a case in point was when the county governments raised concern over the number of health workers they were being invoiced for by the national MoH during the six-month interim phase, claiming that they were being made to pay for ‘ghost workers’ who were not physically present within their counties. At this point, I managed to share my health sector contextual analysis findings at the Health Sector Inter-Governmental Relations Forum, which showed that there was an inherent delay between the times a health worker is posted/ transferred from one station to another, and the date the place of pay is changed. This assisted counties to understand that the discrepancies in actual numbers of staff in their counties were occasioned by this delay. As a result, the counties agreed to reimburse the national government their monies for staff salaries as invoiced

In conclusion, the embedded research approach for this study can thus be used for continued strengthening of the implementation of devolution within the health sector in Kenya, and could also be used for a similar purpose in other LMICs

## **10.2. To decentralise the health sector or not? – Considerations for policy**

Decentralisation has been and continues to be a recurring debate dominating general public sector and health sector specific reforms, particularly in developing countries [1, 7, 8]. There is also a growing acknowledgement that decentralisation is largely a political, rather than technical process [4, 11]. In acknowledging this rather political nature of the decentralisation debate particularly in the health sector, Mitchell and Bossert (2010) argued that the views (the stand) of different health sector actors around this debate will always be influenced by where they are positioned and their role (where they sit) within the health system [59]. The findings of this study largely agree with this assertion.

From the empirical literature reviewed and presented earlier (Chapter 2), it is evident that though health sector decentralisation is a common recommend health sector reform strategy, the experiences for different forms of health sector decentralisation in many LMICs have been, and continue to be mixed both in different countries, and also across different health sector functions within the same country. These decentralisation outcomes have however tended to be influenced by the primary reasons for decentralisations in the country or within the health sector, the form and level of decentralised decision making, and the capacity of the different types of local level decision makers in relation to the decentralised functions [8, 11, 27]. Similarly, the findings of this study (chapters 5,6 and 7) though reporting on early day's experience, also illustrate that there is a relationship between these highlighted factors, and the observed outcomes of the early days of health sector decentralisations in Kenya.

With this observations one wouldn't stop to ask questions like "what is the ideal form of health sector decentralisation?" and "what is the ideal balance in the allocation of functions and accountability roles between the centre and the periphery in a decentralised health system?" It is with these observations from the empirical literature findings; and drawing on the findings from this study that I revisit the conceptual framework described in chapter 4 to propose practical considerations, to inform the continued discussion on the balance between allocation of functions and accountability roles and responsibilities between the centre and the periphery within the health sector. These considerations would not only assist in informing and shaping the decentralisation debates in the Kenyan health sector, but they would also be relevant in other LMIC settings.

As observed in the literature reviewed; even with the acknowledgement of the very political nature of the decentralisation debate, there are very few empirical studies on health sector

decentralisation that have also attempted to undertake an analysis of the broader political context so as to aid in putting into perspective the varied outcomes of health sector decentralisation in developing countries [30, 66, 138]. This study has thus specifically attempted to address that gap in literature. The study's conceptual framework deliberately placed a review and analysis of the broader political context in Kenya at the base of the interactions between the other elements of the framework.i.e. *decision space*, *organisational structure and capacity*, and *accountability* (refer to study conceptual framework chapter 4). This was in acknowledgment that the interaction between these elements of the conceptual framework within the health sector would significantly be affected by the broader political context during the designing and implementation of the decentralisation laws in the country.

Consequently, I have summarized the key historical political events in the country (chapter 3) and specifically drawn lessons of how these informed and affected the overall goals, the design and subsequent implementation process of the devolution laws in the country (chapter 5). In section 9.3 of this chapter, using the policy triangle framework proposed by Walt and Gilson (1994) and Leitcher's policy framework for analysing political context [15, 69], I have analysed and discussed how this broader political context influenced the design and implementation of the devolution goals in Kenya. From the study findings for example, though the health sector through the MoH FACT developed a well-outlined technical plan for implementation of the devolution laws within the health sector, the final implementation process of devolution was driven by political rather than technical considerations, thus putting the health sector in an unprecedented crisis. From the study findings, we also note that certain prompt interventions by key actors and stakeholders helped in averting or addressing some of this crises. For example, the intervention by WB to procure six months' buffer EMMS supplies for all health facilities helped to alleviate a pending major stock out of EMMS in health facilities due to counties un-readiness to take up the EMMS procurement function by the time it had been transferred. Similarly, the national MoH agreed to undertake an interim function of paying health workers salaries for a transition period of six months to allow for counties to develop their payroll management capacity.

The analysis of the broader political context a good understating of the boarder context; thus presenting a better understanding of the health sector effects and outcomes of the early days of implementation of the devolution laws in Kenya. From this analysis, it is evident that the political push for decentralisation is often stronger than the technical implementation process, so there is need for health sector policy actors to have a broader understanding of the countries'

political context whenever designing technical strategies for implementing health sector decentralisation, so as to make their technical implementation strategies responsive to the political contexts. From the findings, I also suggest that it would be important for health sector development partners in LMICs to develop flexible support policies so as to be able to promptly intervene in helping health sectors in LMICs during times of major crisis.

In chapter 9 (section 9.4) I have described and analysed the overall government, and health sector specific organisational structures, and their respective roles and functions in Kenya under the devolved government systems as outlined in the devolution laws in theory. I then further proceeded to analyse the actual different institutional and individual level capacity to carry out respective roles and functions under the devolved system. From my analysis, I have approached capacity as the ability to undertake the allocated function, of which is based on both organisational and institutional arrangements; and on individual knowledge and skills for the individuals within the respective institutions [30]. In addition I considered institutional and individual capacity dimensions around hardware, software tangible, and software intangible elements [71, 72].

From the study findings for example, it is evident that the inability of the CDoH to adequately participate in the 2013/14 fiscal year planning and budgeting process at county level, its inability to appropriately manage staff salaries leading to payroll discrepancies and missing salaries, and inability to appropriately and manage the procurement of EMMS in a timely manner leading to commodity stock outs, was all largely due to lack of appropriate structures and relevant individual capacity to undertake these functions. Once the appropriate structures were established and the individual's capacity progressively improved, there was both an observed and reported improvement in the performance of these functions at the county level. We also note from the findings that there was poor community awareness of their direct community participation role in the county budgeting process; and that MCAs also lacked the appropriate technical skills to participate in the development and appraisal the CIDP and the subsequent 2013/14 county government budget.

From an intervention and policy perspective, there is need to constantly assess the institutional and individual capacity for the different actors in decentralised health system, in respect to their allocated roles and functions. This should subsequently be followed by progressively undertaking relevant capacity building interventions so as to enhance the intended goals of health sector decentralisation. As discussed in chapter 9 (section 9.4) for this study, I utilised

the UNDP capacity assessment criteria and the Aragon framework for undertaking organisational and individual capacity assessment for the different structures and actors involved in implementing health sector devolution, against their roles and functions as outlined in the devolution laws in Kenya. These two are appropriate tools for health sector capacity assessment in decentralised health systems as they have the ability to assess both organisational and institutional arrangements; and knowledge and skills for the individuals within the respective institutions.

From the capacity assessment findings as discussed in section 9.4; as a way of intervention, the CDoH managers in Kilifi County would benefit from technical capacity building initiatives particular around their new roles in county level priority setting, planning and budgeting, HRH management and in the management of EMMS. As highlighted by Doherty and Gilson (2015), this type of technical skills building for health managers would best be delivered through a combination of short-course formal training and on the job training [139]. Similarly, the MCAs in Kilifi would also benefit from formal technical skills strengthening around their oversight roles in the county government planning and budgeting process. This could best be done through formal short-course training initiatives. Finally, community level awareness and capacity strengthening could be undertaken through community barazas and community dialogue forums.

As I highlighted before, several authors have argued that decentralisation debates and decisions around allocation of functions between the centre and the periphery are often political rather than technical [3, 4, 66]. This thus calls for stronger intangible software skills including communication, relationship building and negotiation skills among health sector actors keen on influencing the design and implementation of decentralisation policies [98, 103]. From these study findings for example, we see that though the MoH FACT had developed a technically informed implementation plan for the transfer of functions national to county level, the eventual implementation was driven by a push by political actors; and the health sector actors lacked the appropriate skills to engage with the political actors so as to influence this process of transfer of health sector devolved functions. Similarly, we see that when the healthcare workers were unhappy about them being transferred to county level, they resolved to undertake a country-wide strike to force the county governments to allow them to be managed by national MoH. However, this resolve to use hard-line tactics rather than soft negotiation skills by the healthcare workers was met by an equally hard-line stand by the county government leading to a prolonged strike, and some counties sacking some of the striking health care workers, and

some withholding their salaries. In the long run, the health workers had to eventually call off the strike without achieving what they had wanted.

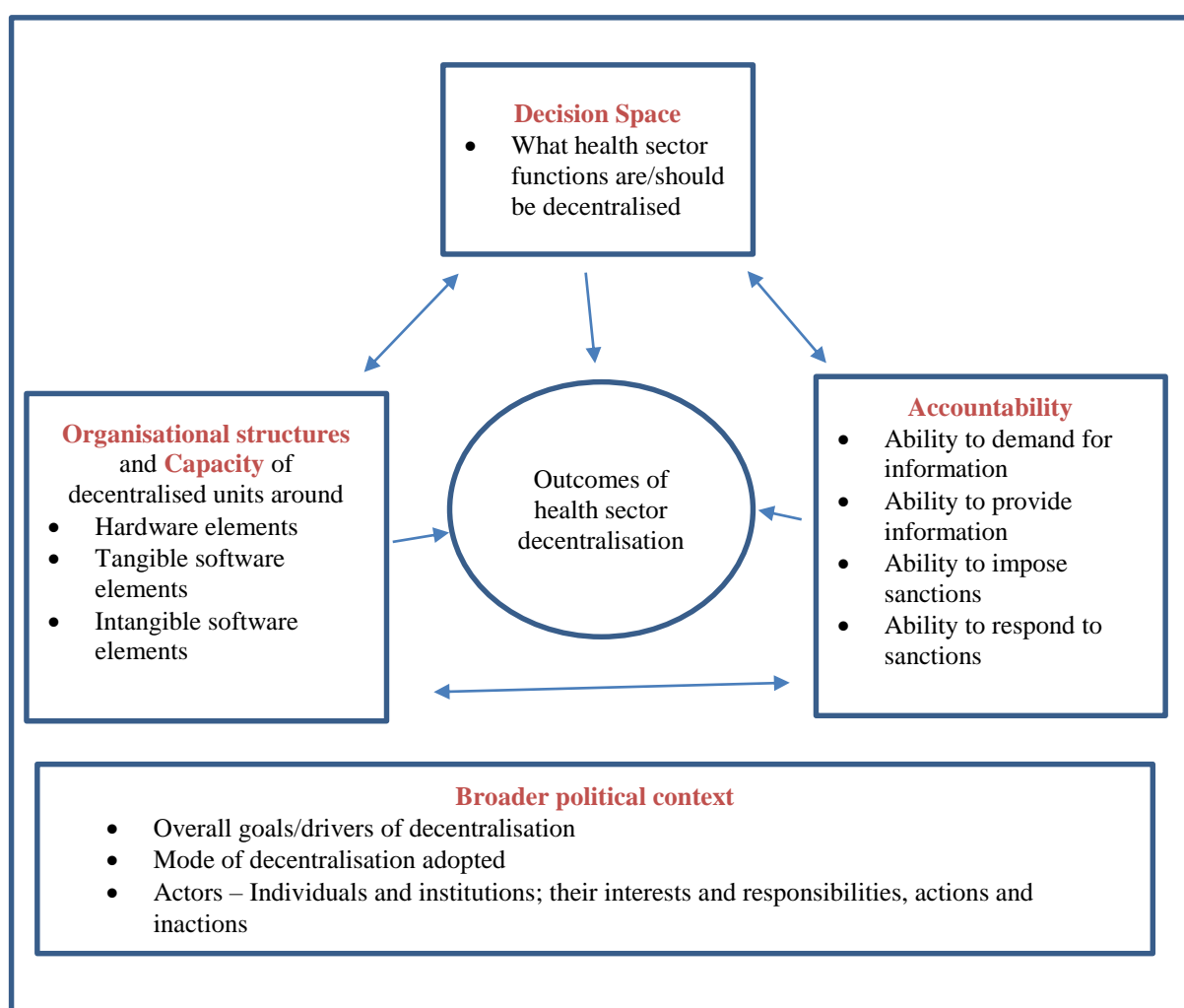
Elloker et al (2010) stressed on the central role of intangible software skills for health managers in their roles of managing day to day crises and routines, which are normal characteristics of the health system [72]. This conviction has more recently also been made by Lehmann and Gilson (2014), and Nyikuri et al (2015) [73, 108]. Worth noting though is that these particular skills element are often missing in the curricular for formal training of most health sector managers [139]. There is thus need for deliberately building on specific interventions aimed at increasing health sector managers' intangible software skills. Doherty and Gilson (2015) have argued that this form of skills building could be done through short training courses followed by long term coaching and mentorship follow-up on the job [139].

On accountability structures and practices in decentralised health system, as I highlighted in section 9.6; I utilised in this study elements of the Brinkerhoff accountability framework which proposes that accountability arrangements should focus on the ability by health sector actors to provide information or respond to sanctions from other actors; and their ability to demand for information or impose sanctions on other actors [18]. From my analysis as presented in section 9.6, we see that lack of capacity can negatively undermine accountability structures in a decentralised setting. For example, it was reported in the findings that the MCAs were unable to meaningfully review and approve the CIDP and the 2013/14 county budget due to their lack of appropriate technical skills to do this, thus undermining an important accountability mechanism in the county level planning and budgeting process. This finding underpins the conceptual framework preposition that in the health sector planning and budgeting function at county level, organisational structure and capacity continuously interacts with and affects accountability processes and practices, thus affecting the decision space of the different actors. These study findings also agree with those of Bossert and Mitchell (2011), who in studying health sector decentralisation in Pakistan also found that decision space around health sector functions within a decentralised setting will always be influenced and affected by the organisational structure and capacity; and the accountability structures and practices [30] From a policy perspective therefore, continued capacity assessment; with the aim of designing appropriate capacity strengthening interventions would serve to improve the functioning of accountability processes within the health sector.

In conclusion based on the review of empirical literature of health sector decentralisation in LMICs and the findings of this study, it is evident that health sector decentralisation outcomes are affected by several factors. Key among these factors are the functions or decisions allocated to the decentralised units, the organisational structures and capacity of decentralised units, the accountability structures and practices and the broader political context within which the decentralisation laws are designed and implemented. From this revelation I argue that even with its perceived benefits, health sector decentralisation policies and strategies, particularly in LMICs cannot be designed from a common ‘one-size fit all’ prescriptive type approach; but need to be undertaken with the background of analysis of these factors. Subsequently I revisit the conceptual framework discussed in chapter 4 and propose that discussion around which health sector functions ought to be decentralised or which ones should remain under central control (*decision space*), should always be considered in the context of the *capacity* to undertake these functions at whichever layer of government they are allocated to, and the *accountability* arrangements around the performance of the said functions by the allocated layer of government.

Figure 16 below is drawn from the conceptual framework described in chapter 4, but specifically goes ahead to summarize key important sub-elements of the conceptual framework that emerged from the study findings and discussed in chapter 9.

Figure 16: Framework to consider in analysing health sector decentralisation



### 10.3. Overall study conclusion

The Kenyan devolution was largely driven by the need to address political rather than technical challenges in public sector management. To this effect, county level functions were rapidly transferred without proper structures and capacity to undertake these functions at county level. This led to major disruption of public services at county level. Within the health sector, the early days witnessed poor participation of the CDoH in county level planning and budgeting, perverse re-centralisation of operational financial management roles from health facility level to the county level, and poor financial flows for addressing recurrent expenses. On HRH, the early days witnessed major disruptions in staff salary payments, political interference with HRH management functions and confusion over certain HRH management roles. This led to strikes and mass resignations by health care workers. On EMMS, although there were significant delays in the procurement process leading to long periods of stock outs of essential drugs in health facilities, once the counties managed to procure, health facilities reported a



better order fill rate of medical supplies compared to the period prior to devolution. County governments also managed to procure commodities for all publicly owned health facilities within their area, irrespective of their gazettelement status.

With time though, and with the county governments establishing their structures and progressively building their capacity, a general improvement in counties' ability to manage devolved functions has been witnessed, including deliberate efforts to find local level solutions to some of the emerging challenges. This has enabled counties to progressively work towards meeting the overall public goals and expectations of devolution. The political will to strengthen the functioning and performance of county governments has also been consistently high. Worth noting especially is the fact that public support for devolution has constantly remained very high even during the transition period associated with major service disruptions [138] .

Based on the findings of this study, I argue that the political push for decentralisation is often stronger than the technical intentions and implementation processes. There is thus need for health sector policy actors to have a broader understanding of the countries' political context whenever designing technical strategies for implementing health sector decentralisation. In addition, I propose that the allocation of functions between central level and decentralised units should always be guided by considerations around the interaction between decision space, organisational structure and capacity, and accountability arrangements and practices within the health system.

#### **10.4. How well did the study meet its objectives?**

This study sought to explore, describe and explain the implications of political decentralization in Kenya on governance and accountability structures and practices for health sector operational planning and budgeting at the sub-national level. The study had three specific objectives namely; (i) describing and analysing the goals and intended strategies of political decentralization for health sector operational planning and budgeting, (ii) describing and analysing stakeholder expectations and experiences of political decentralization for health sector operational planning and budgeting; and (iii) drawing on the empirical data and literature on good governance and accountability to identify strategies for enhancing achievement of decentralisation goals within the health sector. By using a conceptual framework developed from review of relevant literature, the study adequately covered the first and second objectives. In addition, by applying a creative and flexible methodological approach within included both participant and non-participant observations within the context of a health systems governance

learning site (described in details in chapter 4), the study managed to adequately meet its third objective.

## **10.5. Study recommendations**

In light of the findings of this study, I would wish to make the following recommendations;

### *For the Kenyan health sector actors and stakeholders*

- There is need to speed-up the establishment of all the necessary structures required for the efficient handling of the devolved health sector functions in all counties; and to clearly clarify the roles for each of these structures to avoid duplication and overlaps that may lead to constant wrangles amongst actors.
- There is need to constantly evaluate the capacity of the structures charged with responsibility for different health sector functions, and continuously enhance their capacity so as to maximise of the benefits of devolution. Capacity building efforts also need to deliberately include intangible soft skills.

### *For health sector policy elites in other developing countries*

- The political push for decentralisation is often stronger than the technical implementation process, so there is need for health sector policy actors to have a broader understanding of the countries' political context whenever designing technical strategies for implementing health sector decentralisation.
- Assignment of functions (decision space) between the centre and the periphery should be done with the considerations of the necessary capacity to carry out the functions, and accountability structures and practices

### *For research*

- Empirical studies on health sector decentralisation need to deliberately undertake analysis of broader country level political context so as to provide a better understanding of the outcomes of health sector decentralisation in a particular context
- There is need for more research to establish the critical capacity elements for the optimal functioning for CDoH in the decentralised context in Kenya
- There is a need for a more long-term tracking of the health sector effects of decentralisation in Kenya, with an aim of providing an understanding of the critical governance practices that enhance and strengthen the health sector performance in decentralised settings.

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## 12.0. Annexes:

### 12.1. Annex 1: Summary papers included in the literature review

	Study	Country	Study Characteristics	Tracer Elements Featured	Summary of Key Findings
1	<p>Bossert T. et al 2007.</p> <p><i>Is decentralization good for logistics system? Evidence on essential medicine logistics in Ghana and Guatemala</i></p>	Ghana and Guatemala	<ul style="list-style-type: none"> <li>• Cross country surveys of decision space about EMMS in the 2 countries</li> <li>• Qualitative assessment of decision space</li> </ul>	EMMS	<ul style="list-style-type: none"> <li>• Less local level choice was associated with better performance for EMMS inventory control and logistics information system</li> <li>• More local level choice was associated with better performance of EMMS planning and budgeting</li> </ul>
2	<p>Mayhew S, 2003.</p> <p><i>The impact of decentralization on reproductive health services in Ghana</i></p>	Ghana	<ul style="list-style-type: none"> <li>• Multiple level qualitative case study – involving participants at national, regional and district levels of government</li> </ul>	Operational Planning & Budgeting, EMMS and HRH	<ul style="list-style-type: none"> <li>• Two modes of funding for operations; decentralized funds through SWAP and centrally controlled earmarked funds</li> <li>• Maintained two parallel RH commodities supplies systems. One donor funded central control, and a public funded decentralized systems</li> <li>• Commodities bought centrally were cheaper than those bought by districts due to economies of scale</li> <li>• Recruitment, promotion, and discipline of RH staff was initially retained centrally at the head of public service; then later delegated to regions leading to poor staff retention due to uncertainties in career</li> </ul>

					<p>progression and poor working conditions in the districts</p> <ul style="list-style-type: none"> <li>• Districts and regions were allowed to offer incentives in-kind, like trainings and vehicles to staff, but not to increase salaries</li> <li>• Several remote districts became underserved as they could not attract/retain staff due to poor living conditions, lack of communication facilities and lack of schools for children in those areas.</li> </ul>
3	<p>Grundy J et al, 2003.</p> <p><i>Overview of devolution of health services in the Philippines</i></p>	Philippines	<ul style="list-style-type: none"> <li>• Review of literature</li> <li>• Appraisal of the health system in two provinces in the country using observations, interviews and FGDs at the regional level</li> <li>• National level review of documents and reports reporting on health sector performance</li> </ul>	HRH, Planning and budgeting; and EMMS	<ul style="list-style-type: none"> <li>• HW were assigned to the management of non-HW locally elected politicians and their bureaucracies</li> <li>• No prior sensitisation of HWs on their new roles and management structure under devolution</li> <li>• Poor staff morale due to poor transfer process of health workers to the management of locally elected political leaders</li> <li>• Mass resignations by key personnel</li> <li>• Decreased funding by Local Govt leading to low staffing, un-maintained infrastructure, and un-repaired equipment.</li> <li>• Loss of managerial and fiscal control of hospitals by hospital managers – Taken up by regional managerial units</li> <li>• Untimely or decreased procurement of drugs, medicines and supplies by LGU officials</li> </ul>
4	<p>Munga M. et al, 2008.</p> <p><i>The decentralization-centralization</i></p>	Tanzania	<ul style="list-style-type: none"> <li>• Qualitative exploratory study at national level and across five districts in the country</li> </ul>	HRH	<ul style="list-style-type: none"> <li>• Health worker recruited under decentralization its was closely linked with budgeting process.</li> </ul>

	<i>dilemma: recruitment and distribution of health workers in remote districts in Tanzania</i>				<ul style="list-style-type: none"> <li>• Recruitment in decentralized districts was based on actual staff needs in numbers and skills, compared to centralized recruitment</li> <li>• Health worker recruitment in decentralized districts was interfered by influential local politicians</li> <li>• Recruitment of highly skilled health workers under decentralization was difficult and expensive</li> <li>• Centralized recruitment was perceived to be more effective in recruitment and balancing the distribution of highly skilled staff</li> <li>• Management of health personnel at local level was overridden by several central government organs with a stake on public servants management</li> <li>• Decentralized recruitment was effective in improving retention of lower cadre staff</li> <li>• Decentralisation aggravated imbalances in the distribution of health workers across districts</li> </ul>
5	<p>Kyaddondo D and Whyte S, 2003.</p> <p><i>Working in a decentralized system: a threat to health workers' respect and survival in Uganda</i></p>	Uganda	<ul style="list-style-type: none"> <li>• A qualitative case study in 2 districts – 2 health facilities per district</li> <li>• Involved interviews-respondents from the health facilities, sub-county and district managers: observations: and document reviews-Minutes of meetings, letters and memos</li> </ul>	HRH	<ul style="list-style-type: none"> <li>• Decentralization caused confusion in HW employment terms as some HW were employed by decentralized districts while others retained by national level and the 2 groups had different terms of employment</li> <li>• Decentralisation caused confusion and loss of career progression including confirmation and promotion of some HWs</li> </ul>

					<ul style="list-style-type: none"> <li>• Decentralisation led to delayed salary payment with some HWs in the study districts staying as long as 36months without receiving payment</li> <li>• Decentralised districts could not afford to pay for in-service training for HWs, thus decentralization had a negative effect on HW s career progression</li> <li>• Decentralisation weakened HWs positions as professionals in society, as they were managed by Facility Committees with no technical skills. This interfered with HWs facility-based survival strategies like exempting their relatives from user fees payments</li> <li>• HW resulted in establishing supplementary sources of income like opening private clinics and drug shops outside the formal government healthcare system</li> </ul>
6	<p>Mouzinho A and Stewart D, 2001.</p> <p><i>Decentralisation and human resource management in the health sector: a case study (1996-1998) from Napula province, Mozambique</i></p>	Mozambique	<ul style="list-style-type: none"> <li>• Qualitative case study involving one province in the country</li> <li>• Data collected through interviews with provincial managers; and secondary data from provincial and national reports</li> </ul>	HRH	<ul style="list-style-type: none"> <li>• Decentralisation did not improve HR deployment efficiency due to too much bureaucracy at the provincial level</li> <li>• Some positive aspects including improvements with administration of retirement process was noted, and better personnel information system</li> <li>• HR management at provincial level was affected by lack of qualified personnel and proper administrative process to manage the HR function.</li> <li>• Recruitment of HW was poor due to financial constraints at provincial level</li> <li>• HW performance evaluation was never carried out at provincial level due to lack of capacity</li> </ul>

					<ul style="list-style-type: none"> <li>• There were no formal rewards and incentives for HW at the provincial level</li> </ul>
7	<p>Lakshminarayanan R, 2003.</p> <p><i>Decentralisation and its implication of reproductive health: The Philippine experience</i></p>	Philippines	Case study analyzing national level effects of decentralization on RH services at country level	Operational Planning & Budgeting; HRH	<ul style="list-style-type: none"> <li>• Non-earmarked transfer of funds to local level</li> <li>• Resource allocation not based on revenue generating capacity of local level</li> <li>• Curative care bias of local government spending on health</li> <li>• Decentralization led to underfunding of preventive services like family planning</li> <li>• Decentralization did not improve the general efficiency, equity of the health delivery system</li> <li>• Devolved health workers received up to 40% reduced benefits due to lack of resources at the local governments</li> <li>• Devolved health workers made to provide integrated services rather than the initial vertical programmatic service provision – thus increased workload</li> </ul>
8	<p>Bossert &amp; Beauvais 2002.</p> <p><i>Decentralisation of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space</i></p>	Ghana, Zambia, Uganda and the Philippines	A four country comparative case study of decentralisation, analyzing the effect of different forms of decentralisation on the health sector in each of these countries		<ul style="list-style-type: none"> <li>• Ghana and Zambia had deconcentrated system, while Uganda and Philippines had devolved system</li> <li>• Uganda completely devolved health sector budget through a block grant to districts, with exception to personnel salaries</li> <li>• Philippines also entirely devolved health sector budget</li> <li>• In Ghana, percentage public sector financing for health increased with decentralisation</li> <li>• In Zambia, the share of public resources to primary health also increased</li> </ul>

					<ul style="list-style-type: none"> <li>• In both the devolved and decocentrated countries, local resources generation was low, and they heavily relied on central level allocation</li> <li>• Ghana and Zambia had deconcentrated HRH management with more central level control</li> <li>• Uganda and Philipines had devolved HRH management system;, however central level imposed salary</li> <li>• Hospital workers in both Uganda and Philipines were not decentralised and were more likely to receive their salaries in time compared to devolved primary care staff</li> <li>• Decentralisation brought a significant deterioration of employment conditions for health workers in Philipines, and salaries for devolved staff decreased</li> </ul>
9	<p>Frumence G et al 2013.</p> <p>Challenges to the implementation of health sector decentralization in Tanzania: experience from Kongwa district council</p>	Tanzania	<ul style="list-style-type: none"> <li>• A qualitative case study of one district in central Tanzania</li> <li>• Data collected through interviews at local and national levels; and through document review</li> </ul>	Operational Planning and Budgeting, HRH	<ul style="list-style-type: none"> <li>• Increased autonomy in local resource mobilization and utilisation</li> <li>• Enhanced bottom-up planning approach</li> <li>• Inadequate planning skills and capacity at local level</li> <li>• Reduced financial management bureaucratic procedure</li> <li>• Enhanced health worker accountability</li> <li>• Salaries determined by national civil service</li> <li>• Increased political interference at local level</li> </ul>
10	Bossert T et al 2000.	Chile and Bolivia	<ul style="list-style-type: none"> <li>• National level comparative case studies in the two countries.</li> <li>• Collected data from nationally available country level reports</li> </ul>	Operational Planning and Budgeting, HRH	<ul style="list-style-type: none"> <li>• Decentralisation Increased equitable resource distribution to regions through establishment of equalisation fund</li> </ul>



	<i>Decentralisation of health systems in Latin America</i>				<ul style="list-style-type: none"> <li>• There was Limited local level choices on different aspects of HR management including recruitment and salaries</li> </ul>
1 1	Collins C D et al, 2002.  <i>Decentralisation, health care and policy process in Punjab, Pakistan in the 1990s</i>	Pakistan	<ul style="list-style-type: none"> <li>• Case study of one province in Pakistan</li> </ul>	Operational Planning and Budgeting	<ul style="list-style-type: none"> <li>• Health is a co-current function of both federal and devolved governments</li> <li>• Decentralisation Increased financial management responsibilities of planning and budgeting to districts</li> </ul>
1 2	Bossert et al, 1991.  <i>'Bottom-up' planning in Indonesia: decentralization in the ministry of health</i>	Indonesia	<ul style="list-style-type: none"> <li>• Country level case study</li> <li>• Utilises data from available national reports</li> </ul>	Operational Planning and Budgeting	<ul style="list-style-type: none"> <li>• Decentralization enhanced bottom-up planning and budgeting particularly for HW on-job training and for drugs prioritisation</li> </ul>
1 3	Green A et al, 2000.  <i>Resource allocation and budgetary mechanisms for decentralized health systems: experiences from Balochistan, Pakistan</i>	Pakistan	<ul style="list-style-type: none"> <li>• Country level case study comparing the two countries</li> <li>• Utilises data from available national reports</li> </ul>	Operational Planning and Budgeting	<ul style="list-style-type: none"> <li>• Decentralisation increase equitable resource allocation across regions within each country; but did not enhance utilisation efficiency of resources allocated</li> </ul>

1 4	Anders Jeppsson, 2001. <i>Financial priorities under decentralization in Uganda</i>	Uganda	<ul style="list-style-type: none"> <li>Country level case study involving all districts in the country</li> <li>Utilized document review-review of district health sector budgets; and Key informant interviews at selected districts and national level</li> </ul>	Operational Planning and Budgeting	<ul style="list-style-type: none"> <li>Decentralisation led to districts significantly reducing budget allocations to PHC activities to almost a quarter of previous centralised allocation</li> <li>Districts rationale for this included insufficient local revenue, lack of sufficient funds from central govt, high health expenses, and that other sectors contribute to health</li> <li>Conditional funding introduced later enhanced resource utilisation at district level, and increased public health sector funding</li> </ul>
1 5	Bossert T et al 2003 <i>Decentralization in Zambia: resource allocation and district performance</i>	Zambia	<ul style="list-style-type: none"> <li>Country level case study</li> <li>Utilises data from available national reports</li> </ul>	Operational Planning and Budgeting	<ul style="list-style-type: none"> <li>Decentralisation enhanced local internal health sector resource allocation; and user fee levels and utilisation</li> </ul>
1 6	Bossert T et al 2003. <i>Decentralization and equity of resource allocation: evidence from Colombia and Chile</i>	Colombia and Chile	<ul style="list-style-type: none"> <li>Comparative analysis of the two countries using the decision space approach</li> </ul>	Operational Planning and Budgeting	<ul style="list-style-type: none"> <li>Decentralisation achieved equitable levels of per capita resource allocation in both countries through use of allocative formulae</li> </ul>
1 7	McIntyre D and Kulgman B, 2003.	South Africa	<ul style="list-style-type: none"> <li>Country level case study analysing decentralisation</li> </ul>	Operational Planning	<ul style="list-style-type: none"> <li>Decentralisation introduced financial autonomy at provincial and district level</li> </ul>

	<i>The Human Face of Decentralisation and Integration of Health Services; Experiences from South Africa</i>		<ul style="list-style-type: none"> <li>Data collected through interviews at national, regional and district levels</li> </ul>	and Budgeting	<ul style="list-style-type: none"> <li>Did not increase available resource to health sector at local level leading to frustrations of local health managers</li> </ul>
1 8	Bossert T and Mitchell A. <i>Decentralisation, Governance and Health System Performance: 'Where You Stand Depends on Where You Sit'</i>	Bolivia, India, Uganda, Chile, the Philipines and Pakistan	<ul style="list-style-type: none"> <li>Case study of Comparative analysis of the six countries using decision space framework</li> <li>Data collected through analysis of literature including published literature, and country level reports and grey literature</li> </ul>	HRH EMMS, and ;Planning and Budgeting	<ul style="list-style-type: none"> <li>All six countries had a devolved form of government structure</li> <li>There was a high variation of decision space across countries over similar functions; and within countries over different health sector functions</li> <li>Across all countries, HW salaries were centrally restricted. In Bolivia HW were not devolved. Chile HW management discretion was limited to primary care staff only.</li> <li>Bolivia, India and Pakistan had most EMMS elements e.g. Essential drug lists, prices etc.. centralised a national level, Chile had more local choice for using public or private drug suppliers; while Philipines had numerous local EMMS procurement systems</li> <li>India, Pakistan and Uganda – had comparatively high central level conditionality for resource allocation on centrally transferred funds. Bolivia, Chile and Philipines – had low conditionalities on central transferred resources</li> </ul>
1 9	Shayo E et al 2013. <i>Stakeholders' participation in planning and</i>	Tanzania	<ul style="list-style-type: none"> <li>Qualitative case study of one district in Tanzania examining priority setting and budgeting for</li> </ul>	Resource allocation, planning	<ul style="list-style-type: none"> <li>Donor conditions and central level restrictions/directives restricted any meaningful local level priorities in the final district level PMTCT plans and budgets</li> </ul>

	<i>priority setting in the context of a decentralized health care system: the case of prevention of mother to child transmission of HIV programme in Tanzania</i>		<p>PMTCT services within a devolved context</p> <ul style="list-style-type: none"> <li>• Data collection undertaken through interviews with district and regional managers, and through FGDs</li> </ul>	and budgeting	
20	<p>Kapipiri L et al 2003.</p> <p><i>Public participation in health planning and priority setting at the district level in Uganda</i></p>	Uganda	<ul style="list-style-type: none"> <li>• Exploratory qualitative case study</li> <li>• Data collection through national, district and community level interviews, supplemented by community FGDs</li> </ul>	Planning and Budgeting	<ul style="list-style-type: none"> <li>• Districts have power to plan and pass their budgets independent of national ministry</li> <li>• District level planning largely dominated by local elected political leaders and technical personnel and ; and hardly any public participation</li> <li>• District level planning units were happy about not having to consult central ministry for plans and budgets approvals</li> </ul>
21	<p>Dhakal R et al 2009.</p> <p><i>Addressing the challenges of health sector decentralization in Nepal: an inquiry into the policy and implementation process</i></p>	Nepal	<ul style="list-style-type: none"> <li>• Qualitative case study – focusing on national level and one district in the country</li> <li>• Primary data collection through interviews at national level and district. Secondary data through analysis of documents and reports</li> </ul>	Planning and Budgeting; HRH	<ul style="list-style-type: none"> <li>• The planning process remained heavily centralized with minimal ability to make adjustments to budgets allocated</li> <li>• The budget allocated was not based on district needs , funding was inadequate – an health facilities had lost revenue through a new government policy of abolishing user fees for PHC services and free maternity services</li> <li>• HWs expressed their reservations on being decentralised and went on strike to resist the decentralisation</li> </ul>

					<ul style="list-style-type: none"> <li>• HWs, feared losing their jobs and were worried about the ability of districts to pay their salaries</li> </ul>
2 2	Collins C et al 2000.  <i>Decentralizing the health sector: issues in Brazil</i>	Brazil	<ul style="list-style-type: none"> <li>• Country level case study analyzing experience of health sector decentralization in the country</li> </ul>	Planning and Budgeting	<ul style="list-style-type: none"> <li>• Health Units receive allocations from decentralized municipalities and from central government transfers</li> <li>• The central transfers/allocations is similar for all municipalities thus creating inequalities</li> <li>• The municipalities are recommended to allocate upto 10% of local revenue to health; but many do not meet this percentage as this is not obligatory</li> </ul>
2 3	Maluka SO et al 2011.  <i>Decentralization and health care prioritization process in Tanzania: from national rhetoric to local reality</i>	Tanzania	<ul style="list-style-type: none"> <li>• Qualitative case study design of one district in Tanzania</li> <li>• Utilised multiple qualitative techniques including document reviews, observations, KIIs and FGDs</li> </ul>	Planning and Budgeting	<ul style="list-style-type: none"> <li>• Through local priority setting was devolved to district health authorities in theory, existence of restrictive planning guidelines and budget ceilings provided by central government; reduced the ability of district managers to plan and allocate funds based on local priorities</li> <li>•</li> </ul>
2 4	Anokbonggo WW et al, 2004.  <i>Impact of decentralization on health services in Uganda: a look at facility utilization, prescribing and availability of essential drugs</i>	Uganda	<ul style="list-style-type: none"> <li>• Case Study of two districts in Uganda</li> <li>• Mixed Methods:- Quantitative- Time series data collection on drug availability in health facilities</li> <li>• Qualitative- KIIs and FGDs on district level stakeholders</li> </ul>	EMMS	<ul style="list-style-type: none"> <li>• Health facilities received drug kits whose size and contents determined by central level MoH with minimal input from districts</li> <li>• Districts/Health facilities supplemented drugs supply using user fees and other locally generated resources</li> <li>• Drugs availability at health facilities was erratic and always inadequate</li> </ul>

2 5	Kivumbi GW et al, 2004. <i>Financial management systems under decentralization and their effect on malaria control</i>	Uganda	<ul style="list-style-type: none"> <li>• Descriptive case study of four districts in Uganda</li> </ul>		<ul style="list-style-type: none"> <li>• There existed long tedious bureaucratic process for utilisation of conditional grants earmarked for PHC activities; which affected timely use of financial resources for control of communicable diseases</li> <li>• Existed lots of vertical disease control programme funded centrally</li> </ul>
2 6	Okorafor O and Thomas S, 2007. <i>Protecting resources for primary health care under fiscal federalism: options for resource allocation</i>	South Africa	<ul style="list-style-type: none"> <li>• A qualitative case study design across 3 of the 9 provinces in the country</li> </ul>	Priority setting, planning and budgeting	<ul style="list-style-type: none"> <li>• PHC budgets are determined by province department of health with no interference from national MoH</li> <li>• Each province does its budgetary allocation totally independently</li> <li>• Allocation to PHC are done incrementally on historical basis and lack a need basis</li> </ul>
2 7	Mubyazi G et al, 2004. <i>Implications of decentralization for the control of tropical diseases in Tanzania: a case study of four districts</i>	Tanzania	<ul style="list-style-type: none"> <li>• Exploratory qualitative case study of four districts utilizing KIIs, FGDs and documents reviews</li> </ul>	HRH, EMMS, Resource allocation Planning and budgeting	<ul style="list-style-type: none"> <li>• All HRH management function including hiring, disciplining and remuneration transferred to the local councils</li> <li>• Essential drug kits purchased and distributed by central MoH to health facilities with no input from district on composition of kits</li> <li>• Annual district work plans have to be approved by central MoH before funds are allocated</li> <li>• Less than 5% of health budget was from locally mobilised resources</li> </ul>

28	Mills A et al, 2002. <i>The distribution of health planning and management responsibilities between centre and periphery: historical patterns and reform trends in four Caribbean territories</i>	Trinidad and Tobago, Bahamas, Martinique and Suriname	<ul style="list-style-type: none"> <li>Country level analysis of the historical evolution of the health system in the 4 countries</li> </ul>	HRH, Resource allocation, planning and budgeting	<ul style="list-style-type: none"> <li>Adopted a delegated form of decentralisation through creation of hospital boards in Bahamas, regional health authorities in T&amp;T ; and Regional Agency for Hospitals in Martinique</li> <li>Revenue raisin role retained centrally in Matrtrinuque, while delegated units in Bahamas and T&amp;T had power to raise local revenue and retain it</li> <li>Personnel in the Bahamas employed by the hospital boards, in T&amp;T –regions recruited new staff while existing staff given choice of transfer, secondment or remaining centrally employed; while in Martinique there were no changes in staff management</li> </ul>
29	Gilson L, et al 1994. <i>Local government decentralization and the health sector in Tanzania.</i>	Tanzania	<ul style="list-style-type: none"> <li>Qualitative evaluation of health system decentralisation as experienced by district managers</li> </ul>	HRH, EMMS, Planning and budgeting	<ul style="list-style-type: none"> <li>Health staff employed by, and fully responsible to district councils</li> <li>Drugs procured and delivered to health facilities through a vertically organised programme. Decision on kit contents taken by national MoH with not input locally.</li> <li>Very low level of local decision space over several functions due to limited ability of districts to raise significant local resources, non-transparent national resource allocation procedures, many vertical donor funded health programmes, creation of many layers of responsibility, authority and accountability confusing technical officers.</li> </ul>

## 12.2. Annex 2: Constitution of Kenya 2010 – Schedule Four

### FOURTH SCHEDULE (*Article 185 (2), 186 (1) and 187 (2)*) DISTRIBUTION OF FUNCTIONS BETWEEN THE NATIONAL GOVERNMENT AND THE COUNTY GOVERNMENTS

#### Part 1—National Government

1. Foreign affairs, foreign policy and international trade.
2. The use of international waters and water resources.
3. Immigration and citizenship.
4. The relationship between religion and state.
5. Language policy and the promotion of official and local languages.
6. National defence and the use of the national defence services.
7. Police services, including—
  - (a) the setting of standards of recruitment, training of police and use of police services;
  - (b) criminal law; and
  - (c) correctional services.
8. Courts.
9. National economic policy and planning.
10. Monetary policy, currency, banking (including central banking), the incorporation and regulation of banking, insurance and financial corporations.
11. National statistics and data on population, the economy and society generally.
12. Intellectual property rights.
13. Labour standards.
14. Consumer protection, including standards for social security and professional pension plans.
15. Education policy, standards, curricula, examinations and the granting of university charters.
16. Universities, tertiary educational institutions and other institutions of research and higher learning and primary schools, special education, secondary schools and special education institutions.
17. Promotion of sports and sports education.
18. Transport and communications, including, in particular—
  - (a) road traffic;
  - (b) the construction and operation of national trunk roads;
  - (c) standards for the construction and maintenance of other roads by counties;
  - (d) railways;
  - (e) pipelines;
  - (f) marine navigation;
  - (g) civil aviation;
  - (h) space travel;
  - (i) postal services;
  - (j) telecommunications; and
  - (k) radio and television broadcasting.
19. National public works.
20. Housing policy.
21. General principles of land planning and the co-ordination of planning by the counties.
22. Protection of the environment and natural resources with a view to establishing a durable and sustainable system of development, including, in particular—



- (a) fishing, hunting and gathering;
  - (b) protection of animals and wildlife;
  - (c) water protection, securing sufficient residual water, hydraulic engineering and the safety of dams; and
  - (d) energy policy.
23. National referral health facilities.
  24. Disaster management.
  25. Ancient and historical monuments of national importance.
  26. National elections.
  28. Health policy.
  29. Agricultural policy.
  30. Veterinary policy.
  31. Energy policy including electricity and gas reticulation and energy regulation.
  32. Capacity building and technical assistance to the counties.
  33. Public investment.
  34. National betting, casinos and other forms of gambling.
  35. Tourism policy and development.

## Part 2—County Governments

The functions and powers of the county are—

1. Agriculture, including—
  - (a) crop and animal husbandry;
  - (b) livestock sale yards;
  - (c) county abattoirs;
  - (d) plant and animal disease control; and
  - (e) fisheries.
2. County health services, including, in particular—
  - (a) county health facilities and pharmacies;
  - (b) ambulance services;
  - (c) promotion of primary health care;
  - (d) licensing and control of undertakings that sell food to the public;
  - (e) veterinary services (excluding regulation of the profession);
  - (f) cemeteries, funeral parlours and crematoria; and
  - (g) refuse removal, refuse dumps and solid waste disposal.
3. Control of air pollution, noise pollution, other public nuisances and outdoor advertising.
4. Cultural activities, public entertainment and public amenities, including—
  - (a) betting, casinos and other forms of gambling;
  - (b) racing;
  - (c) liquor licensing;
  - (d) cinemas;
  - (e) video shows and hiring;
  - (f) libraries;
  - (g) museums;
  - (h) sports and cultural activities and facilities; and
  - (i) county parks, beaches and recreation facilities.
5. County transport, including—
  - (a) county roads;
  - (b) street lighting;
  - (c) traffic and parking;
  - (d) public road transport; and

- (e) ferries and harbours, excluding the regulation of international and national shipping and matters related thereto.
- 6. Animal control and welfare, including—
  - (a) licensing of dogs; and
  - (b) facilities for the accommodation, care and burial of animals.
- 7. Trade development and regulation, including—
  - (a) markets;
  - (b) trade licences (excluding regulation of professions);
  - (c) fair trading practices;
  - (d) local tourism; and
  - (e) cooperative societies.
- 8. County planning and development, including—
  - (a) statistics;
  - (b) land survey and mapping;
  - (c) boundaries and fencing;
  - (d) housing; and
  - (e) electricity and gas reticulation and energy regulation.
- 9. Pre-primary education, village polytechnics, homecraft centres and childcare facilities.
- 10. Implementation of specific national government policies on natural resources and environmental conservation, including—
  - (a) soil and water conservation; and
  - (b) forestry.
- 11. County public works and services, including—
  - (a) storm water management systems in built-up areas; and
  - (b) water and sanitation services.
- 12. Fire fighting services and disaster management.
- 13. Control of drugs and pornography.
- 14. Ensuring and coordinating the participation of communities and locations in governance at the local level and assisting communities and locations to develop the administrative capacity for the effective exercise of the functions and powers and participation in governance at the local level.

### 12.3. Annex 3: Data Collection Tools

#### Generic interview guide

Domain	Theme	Initial questions	Additional probes after document reviews and observations
Introduction	Individual introduction	What is your position/role in the health sector?	
		For how long have you been in that position/role?	
		What was your role position prior to this?	
	Institutional introduction	What is the role of your current management position/institution? Is it different from what was there prior to the implementation of the 2010 constitution? How different is it?	How clear is your role/how does the fit in the current national MoH organogram
Background	Context	In your view what led to the country's adoption of devolution in the 2010?	What was the role of perceived historical injustices in managing government affairs and resource distribution
		What is the devolution policy intended/expected to achieve in the county in general? What is it expected to achieve in the health sector specifically?	How is national resource allocation/distribution more equitable compared to the period before devolution
	Content	How are/will the devolved counties be structurally and operationally different from the districts and provinces that existed prior to the adoption for the 2010 constitution?	How much influence does national government have on county operations?
		How is/will this structural and operational difference be particularly within the health sector?	How much influence does national MoH have over the operations of the County Department of Health
		Is there an official policy and guideline document on how the central government will interact/relate with	How is the linkage between the national and county government planning and M&E frameworks? How are these coordinated?

		the devolved governments regarding operational planning and budgeting within the health sector?	What is the role of the recently established “Inter governmental relations forum” on the planning and M&E process in the sector
		What opportunities/challenges does this bring about?	
	Actors	Who were the main actors that were involved/influenced the adoption of the devolved county government structure in the 2010 constitution?	What was the role of politicians? Civil society? And Donor organisations?
		Who were the main actors involved in adaptation of the devolution within the health sector?	What has been the role of central MoH? Role of County Governments? Role of other government/constitutional organs? Health NGOs? Donors in the Sector?
		Who are the main actors charged with the responsibility of implementing the devolution policy from the national level, especially in the health sector? How do these actors interact?	Role of Sr Management at national MoH? Role of Health Sector Planning Units? Role of Sector Partners and Donors? Role of other government/constitutional organs?
		Who are the main actors charged with the responsibility of implementing the devolution policy at the county level, especially in the health sector? How do these actors interact?	Role of Transition Authority? Role of CECs-Health? Role of Interim County Directors and CHMTs?
	Process	How is the devolution process being/ How is it to be implemented?	In your view what explains the discrepancy (if any) on what is to be done in paper and what is actually being done?
		How is the devolution process being/ How will it be implemented in in the health sector?	In your view what explains the discrepancy (if any) on what is to be done in paper and what is actually being done?
		At what point does full implementation of the devolution occur at the county level within the health sector?	How timely will this be achieved?

Organizational Capacity	Institutional Capacity	What are the new/proposed subnational level structures and institutions that are/will be charged with managing and coordinating health services?	Is there an official guideline to counties on the composition and roles of these structures?
		How are/will these institutions be structurally and operationally different from those that existed prior to the adoption of the new constitution?	
		Are there mechanisms in place to train and orientate these new institutions/ structures on their roles of managing and coordinating health services at the subnational level?	
		What opportunities/challenges have/will been/be brought about by these new institutions in the health sector at the subnational level	
	Individual Capacity	What is the profile (training and experience) of the actors operating in the subnational level management institutions and structures that manage and coordinate the health sector at that level? How are these different from those that existed prior to the adoption of the 2010 constitution?	What formal orientation/training was/will be organized for the county health managers?
		What capacity (training and experience) do the actors in the sub-national level health sector management structures have/expected to have regarding human resources planning and management?	
		What capacity (training and experience) do the actors in the sub-national level health sector management structures have/expected to have regarding drugs and commodities supplies and management?	
		What opportunities/challenges have/will been/be brought about by these actors in the subnational level health sector management institutions and structures?	

Decision Space	General operational planning and budgeting	How much autonomy do/will the sub-national health management structures have regarding operational planning and budgeting? How has this changed from the period prior to the adoption of the new constitution?	How is this happening during this transition phase? Who is approving the operational quarterly budgets? Who is issuing the AIEs?
		How is this autonomy exercised/expected to be exercised	
		What opportunities/challenges has this autonomy brought/expected to bring?	
		What sanctions exist with failure to comply with directives from 'above'?	
	Human Resource Management	How much autonomy do/will the sub-national health management units have regarding planning and management of human resources? How is this/will this be different from the period prior to the adoption of the new constitution?	Who is responsible for recruitment, deployment, disciplining and capacity development of health workers? How is the health workforce being managed, including being remunerated in this transition phase?
		How is this autonomy exercised/expected to be exercised	
		What opportunities/challenges has this autonomy brought/expected to bring?	How has been the experience so far in staff recruitment, deployment and salary payments?
	Drugs and Commodities Supplies Management	How much autonomy do/will the sub-national health management units have regarding planning and management of drugs and commodities? How is this/will this be different from the period prior to the adoption of the new constitution?	What has been the practice in this transition phase?
		How is this autonomy exercised/expected to be exercised?	

		What opportunities/challenges has this autonomy brought/expected to bring?	
Accountability	Accountability to national level MoH	Are there mechanisms of ensuring that the subnational level health sector management units factor in national level policies, strategic goals and guidelines, during their planning and budgeting for the health sector within their areas? How are these mechanisms different from what existed before the adoption of the new	
		What are these mechanisms? How are these mechanisms different from what existed before the adoption of the new constitution?	
		Are there any sanctions or incentives that the central MoH have for reinforcing adherence to national level policies and guidelines by subnational level health sector management units? What are these sanctions/incentives? How are these different from what existed prior to the adoption of the 2010 constitution?	
		What opportunities/challenges do these bring about?	
	Accountability to local elected leaders	What mechanisms are in place to ensure that subnational level health sector management units consult local elected leaders during planning and budgeting for the health sector within their areas?	What has been the experience in this transition phase?
		What mechanisms are in place to ensure that subnational level health sector management units involve local elected leaders during planning and budgeting for the health sector within their areas?	

		What mechanisms are in place to ensure that subnational level health sector management units respond to concerns of local elected leaders during planning and budgeting for the health sector within their areas? How are these mechanisms different from what existed before the adoption of the new constitution?	
		What sanctions or/and incentives exist reinforcing the involvement and consultation with local elected leaders by subnational level health sector management units? How are these different from what existed prior to the adoption of the 2010 constitution?	What has been the experience in this transition phase?
		What opportunities/challenges do these bring about?	
	Accountability to the general community	What mechanisms are in place to ensure that subnational level health sector management units consult, involve and respond to concerns of local community members during planning and budgeting for the health sector within their areas? How are these mechanisms different from what existed before the adoption of the new constitution?	What has been the experience in this transition phase?
		What sanctions or/and incentives exist reinforcing the involvement and consultation with local community by subnational level health sector management units? How are these different from what existed prior to the adoption of the 2010 constitution?	What has been the experience in this transition phase?
		What opportunities/challenges do these bring about?	
		What do health managers do if the accountability requirements to national ministry, to local elected leaders and to the community are in conflict with each other?	What has been the experience in this transition phase?



## Generic observation checklist

National Level Observations		
Context	Before the 2013 general election	National/political mood regarding devolution during drafting and enactment of new constitution
	After the 2013 general elections	National/political mood regarding devolution during the campaigns and the general elections
Process	Before the 2013 general election	Preparation for the devolved government units
		Preparation for devolution within the health sector. Subsidiary legislation to facilitate devolution. Formation of institutions to facilitate and manage the transition to devolution.
		Appointment of interim county government managers
	After the 2013 general election	Outcome of the general election. Which party won the national election? Election disputes.
		Appointment of national cabinet and senior MoH managers at central level
		Development of the national health policy in line with the new constitution
		Development of the national health sector strategic plan in line with the new policy
		Discussion and restructuring of central MoH to conform with its new role in the devolved government system
Actors	Before the 2013 general election	Role of incumbent government
		Role of opposition parties
		Role of civil society and general population
		Institutions charged with the transition to devolved governments and their roles
	After the 2013 general election	Role of winning government
		Role of opposition parties
		Institutions charged with the transition to devolved governments and their roles
County Level Observations		
Context	Before the 2013 general election	Local/Kilifi political mood during the drafting and enactment of the constitution
	After the 2013 general election	Local/Kilifi political mood regarding devolution during the campaigns and the general elections
		Local NGOs operating in the county and influencing health sector management and planning

		Local NGOs working in the county and influencing the decentralization, particularly in the health sector
Process	Before the 2013 general election	Preparation for the devolution
		Appointment and role of interim county government managers
	After the 2013 general election	Outcome of elections at the county? Which party/candidates won? What's their relationship with the national government?
		Swearing in and orientation of governors and County Assembly Representatives
		Appointment of County Cabinet. Induction and orientation
		Appointment of county health management team. Induction and orientation
		Formation of sub-county health management structures
Actors	Before the 2013 general elections	Role of local political leaders
		Role of interim county health managers
	After the 2013 general election	Role of county elected leaders
		Role of county government managers
		Role of County health committee

## 12.4. Annex 4: Thematic Frame

1.0	Theme 1: Overall and health sector goals of devolutions					
	<i>Sub Themes</i>		<i>Codes</i>	<i>Document Reviews</i>	<i>Interviews</i>	<i>Observations</i>
1.1	Goals	1.1.1	Overall			
		1.1.2	Health sector			
2.0	Theme 2: Overall Expectations and Implementation Experiences of Devolution					
2.1	Organizational structure and relations	2.1.1	National Level Structure, Roles and Capacity			
		2.1.2	County Level Structure, Roles and Capacity			
		2.1.3	National Vs County level reporting/accountability relationship			
		2.1.4	Community participation and involvement			
		2.1.5	Lack of clarity/Understanding, disagreements/debates, contests and resistance to change			
2.2	Resources (financial?)	2.2.1	Overall government resources			
		2.2.2	Community involvement/participation			
2.3	The transitional period	2.3.1	Intended and Actual process, timing and roles of key actors			
		2.3.2	Broader political influences and public debates			
2.4	Overall outcomes	2.4.1	Business as usual, no real change			
		2.4.2	Dialogue, consensus building and agreements			
		2.4.3	Things are worse			
		2.4.5	(Remaining) Hopes and Expectations			
		2.4.6	Fear, anxiety and discomfort about the change			
3.0	Theme 3: Health Sector Financial Resource Availability, Priority Setting, Planning and Budgeting					
3.1	Allocating and accounting for resources	3.1.1	Amounts and sources of funds			
		3.1.2	Internal accountability - Central vs County level accounting/reporting			

		3.1.3	Community/ Public participation/ voices in health sector financial management			
3.2	Within county structure and relations	3.2.1	Organization of the county finance management system			
		3.2.2	County treasury vs County Department of Health roles in management of health sector finances			
3.3	Key issues and experiences in management of health finances	3.3.1	Budgeting process for health sector finances 2014/15			
		3.3.2	Confusion and lack of clarity on roles and responsibilities in financial management			
		3.3.3	Delays in access/release of funds			
		3.3.4	Coping mechanisms			
4.0	Theme 4: Health Work Force Management					
4.1	HW management structures, roles and capacity.	4.1.1	National/County/sub-county roles and accountability			
		4.1.2	Capacity to perform roles			
		4.1.3	Community involvement/accountability			
4.2	Key Issues/Experiences in HW management	4.2.1	Hurried transfer of health workforce management into counties and associated debates			
		4.2.2	Fears, tensions, confusions and industrial disputes			
		4.2.3	Absorption of seconded health workers into counties			
		4.2.4	Delayed salaries and payroll discrepancies			
		4.2.5	Political interference/influence in health workforce management			
5.0	Theme 5: Essential Medicine and Medical Supplies					
5.1	Structures, Key actors and their roles and capacity	5.1.1	National/County/Sub-County roles and accountability			
		5.1.2	County treasury			
		5.1.3	County department of health/County Pharmacist			

		5.1.4	Health facility managers			
		5.1.5	KEMSA composition, structure and its roles/ capacity			
		5.1.6	Public Participation in EMMS Management			
		5.1.7	Confusion and Lack of clarity of EMMS roles and responsibilities			
5.2	Key Issues/Experiences	5.2.1	Procurement and distribution of EMMS			
		5.2.2	Availability of EMMS in health facilities			
6.0	Free Codes					
6.1		6.1.1	Power and Control			
		6.1.2	CIC Structure, Roles and responsibilities			
		6.1.3	Community participation (cross cutting across themes)			
		6.1.4	General budgeting and planning (Not specific to health)			
		6.1.5	Operational challenges (Finances/staff/capacity)			

## 12.4. Annex 5: Copy of ethical approval letters

### LSHTM Ethical Approval

**London School of Hygiene & Tropical Medicine**  
Keppel Street, London WC1E 7HT  
United Kingdom  
Switchboard: +44 (0)20 7636 8636  
[www.lshtm.ac.uk](http://www.lshtm.ac.uk)



#### Observational / Interventions Research Ethics Committee

Lucy Gilson  
Professor of Health Policy and Systems  
PHP  
LSHTM

20 September 2012

Dear Professor Gilson,

**Study Title:** Development of district/county level learning sites for the investigation of health system planning, management and accountability mechanisms  
**LSHTM ethics ref:** 6250

Thank you for your application of 8 August 2012 for the above research, which has now been considered by the Observational Committee.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
LSHTM ethics application	n/a	08/08/2012
Learning site proposal including information sheet & consent form		

#### After ethical review

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form. All studies are also required to notify the ethics committee of any serious adverse events which occur during the project via form E4. At the end of the study, please notify the committee via form E5.

Yours sincerely,

**Professor Andrew J Hall**  
Chair  
[ethics@lshtm.ac.uk](mailto:ethics@lshtm.ac.uk)  
<http://intra.lshtm.ac.uk/management/committees/ethics/>

## KEMRI Ethical Approval



# KENYA MEDICAL RESEARCH INSTITUTE

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E-mail: [director@kemri.org](mailto:director@kemri.org) [info@kemri.org](mailto:info@kemri.org) Website: [www.kemri.org](http://www.kemri.org)

**KEMRI/RES/7/3/1**

**May 31, 2012**

**TO: DR. CATHERINE MOLYNEUX (PRINCIPAL INVESTIGATOR)**

**THROUGH: DR. SABAH OMAR  
THE DIRECTOR, CGMR-C,  
KILIFI**

*Forwarded*  
*5/6/12*  
DIRECTOR  
CENTRE FOR GEOGRAPHIC MED  
RESEARCH, COAST

Dear Madam,

**RE: SSC PROTOCOL No. 2205- 2<sup>ND</sup> REVISION (RE-SUBMISSION): DEVELOPMENT OF DISTRICT/COUNTY LEVEL LEARNING SITE FOR THE INVESTIGATION OF HEALTH SYSTEM PLANNING, MANAGEMENT AND ACCOUNTABILITY MECHANISMS**

Reference is made to the e-mail communication dated Wednesday, 23<sup>rd</sup> May 2012. The ERC Secretariat acknowledges receipt of the revised proposal on 31 May 2012.

This is to inform you that the Committee determines that the issues raised at the 200<sup>th</sup> ERC meeting of 17<sup>th</sup> April 2012 are adequately addressed. Consequently, the study is granted approval for implementation effective this **31<sup>st</sup> day of May 2012** for a period of one year.

Please note that authorization to conduct this study will automatically expire on **May 30, 2013**. If you plan to continue data collection or analysis beyond this date, please submit an application for continuation approval to the ERC Secretariat by **April 18, 2013**. The regulations require continuing review even though the research activity may not have begun until sometime after the ERC approval.

You are required to submit any proposed changes to this study to the SSC and ERC for review and the changes should not be initiated until written approval from the ERC is received. Please note that any unanticipated problems resulting from the implementation of this study should be brought to the attention of the ERC and you should advise the ERC when the study is completed or discontinued.

Work on this project may begin.

Sincerely,  
*[Signature]*  
**DR. CHRISTINE WASUNNA,  
ACTING SECRETARY,  
KEMRI ETHICS REVIEW COMMITTEE**



In Search of Better Health

## 12.5. Annex 6: Copy of generic informed consent form

Formal Title: Examining the effects of political decentralisation in Kenya, on governance and accountability structures and practices for sub-national level health sector operational planning and budgeting

Institution	Individuals
KEMRI-Wellcome Research Programme	Benjamin Tsofa, Sassy Molyneux
London School of Hygiene and Tropical Medicine, UK	Catherine Goodman
Health Economics Unit, Cape Town, SA	Lucy Gilson

What is KEMRI and what is this research about?

My name is \_\_\_\_\_. I work for KEMRI, which is a government organization under the Ministry of Public Health and Sanitation and the Ministry of Medical Services. KEMRI conducts research activities to learn more about health and illnesses in Kenya, including health systems research.

We are conducting this research to learn more about how health systems are organised and managed at district/sub-county. We are particularly interested in if and how you undertake operational planning and budgeting and how that has been/will be affected by the implementation of the new constitution in Kenya.

We are talking to a range of people at district/sub-county, county and national level. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you individually/in a group [where a group, state who else is included in the group].

---

[Where taping]: If you agree, the discussion will be tape-recorded to assist later in fully writing up the information. No-one will be identified by name on the tape.

### Voluntary Participation

Participation in this study is voluntary. If you agree to help with this research and later change your mind you are free to withdraw at any time. The discussion should take approximately one hour.

### Confidentiality

---

We are not here to inspect or audit the facility. The information will be used for research purposes only. No one other than the following research team members [*names of the few who will actually read the transcripts,*] will be allowed to see the record of the interview. We will not disclose your identity, or use your name in any reports of this work. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities.



[For group discussions]: We will ask everybody in the discussion to keep what is said in the group confidential, but it is important to recognize that we cannot stop participants sharing what they have heard.

#### Approval for and benefits of this work

The study has been approved by the ethics committee of KEMRI and by national and county health managers. The study will contribute new ideas and insights regarding health system management.

---

#### What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the research team using the contacts below:

Benjamin Tsofa or Sassy Molyneux

P.O.Box. 230, Kilifi

Telephone: 041 7522 063 (KEMRI-Wellcome Trust), or [insert study mobile number]

If you want to ask someone independent anything about this research please contact

Community Liaison Manager, KEMRI – Wellcome Trust

P.O.Box 230, Kilifi. Telephone: 0723342780 or 041 7522 063

Or

The Secretary - KEMRI/National Ethics Review Committee

P. O. BOX 54840-00200, Nairobi, Tel number: 020 272 2541 Mobile: 0722205901 or 0733400003

#### CONSENT FORM -

I have had the study explained to me. I have understood all that has been read and had my questions answered satisfactorily

☐ Yes *please tick* I agree to be interviewed *[if applicable; on behalf of the group]*

☐ Yes *please tick* I agree for the interview to be tape-recorded *[if applicable; on behalf of the group]*

I understand that I can change my mind at any stage and it will not affect me in any way.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Time: \_\_\_\_\_  
Name (please print name)

I certify that I have followed the study SOP to obtain consent from the [participant]. S/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Designee/investigator's Name: \_\_\_\_\_ Time: \_\_\_\_\_  
(please print name)

## 12.7. Annex 7: Map outlining the embeddedness of the KEMRI-WTRP Kenyan Learning Site Researchers

### MAPPING KEMRI | Wellcome Trust RESYST RESEARCHERS' INFLUENCES ON POLICY AND PRACTICE



#### EDWINE BARASA



In my research I have developed a framework for setting and evaluating healthcare priorities. I have drawn on this during policy discussions about how Kenya should structure its purchasing arrangements to improve efficiency and equity. I Chair the technical working group that develops proposals for the healthcare purchasing arrangements and benefits package within the country.

I am also a member of a technical working group responsible for developing and implementing a health insurance subsidy program for the poor, and for developing strategies to improve coverage among the informal sector.

[WATCH EDWINE BARASA'S IMPACT STORY](#)

#### EDWINE BARASA & BENJAMIN TSOFA

In our research relating to priority setting practices in public hospitals, we found that hospitals rely heavily on user fee revenue to finance services. When user-fee funds were disrupted following devolution, we worked through our many formal and informal networks to ensure that short and long term strategies were put in place to keep hospitals open and functioning. This was particularly important for the poorest populations who cannot afford alternative health care.

[WATCH EDWINE AND BENJAMIN'S IMPACT STORY](#)

#### BENJAMIN TSOFA



My experience in the health sector began as a clinician before moving into hospital and public health management.

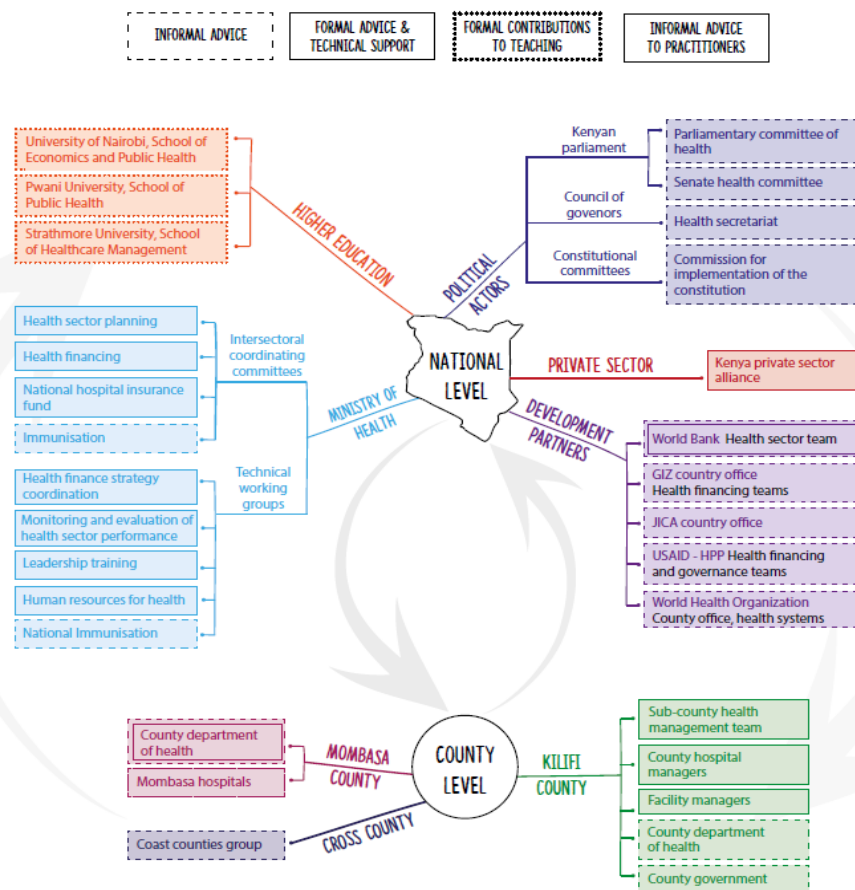
My research investigates health systems governance with a focus on planning, budgeting, priority setting and the impact of political devolution on the health sector. I have provided technical advice at both county and national levels; supporting policy development, building tools and guidelines for budgeting and planning as well as translating these frameworks into practice.

[WATCH BENJAMIN TSOFA'S IMPACT STORY](#)

#### MARY NYIKURI

I research day-to-day management practices of sub-county managers and how they interact with and support primary health care facility managers. I meet regularly with sub-managers and facility in-charges to interview and observe, and feedback my observations which can lead to change. Following my feedback regarding the lack of preparedness of facility in-charges to carry out crucial roles, a sub-county manager introduced new induction processes and terms of reference for facility managers.

[WATCH MARY NYIKURI'S IMPACT STORY](#)



Source: Resilient and Responsive Health Systems - <http://resyst.lshtm.ac.uk/resources/KEMRI-policy-map>